MEDICARE FINANCING CRISIS AND RECOMMENDATIONS FOR MEDICARE FINANCIAL REFORMS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

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MEDICARE FINANCING CRISIS AND RECOMMENDATIONS FOR MEDICARE FINANCIAL REFORMS

THURSDAY, SEPTEMBER 13, 1984

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met at 10 a.m., pursuant to notice, in room 1100, Longworth House Office Building, Hon. Andy Jacobs, Jr. (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

[Press Release No. 10, Thursday, Aug. 30, 1984]

THE HONORABLE ANDY JACOBS, JR. (D., IND.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, TODAY ANNOUNCED THE SECOND IN A SERIES OF HEARINGS ON THE MEDICARE FINANCING CRISIS AND RECOMMENDATIONS FOR MEDICARE FINANCIAL REFORMS TO BE HELD ON THURSDAY, SEPTEMBER 13, 1984

The Honorable Andy Jacobs, Jr. (D., Ind.), Chairman of the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on Thursday, September 13, 1984. This is the second in a series of Subcommittee hearings on the medicare financing crisis and possible solutions to this financing problem. The hearing will be held in room 1100 Longworth House Office Building, beginning at 10:00 a.m. During the first day's hearing, held on March 30, 1984, the Subcommittee heard from the Advisory Council on Social Security on the Council's recommendations regarding the medicare trust fund. The witnesses for the Advisory Council were its Chairman, former Indiana Governor Otis P. Bowen, M.D., and Mr. Stanford D. Arnold.

It is the Subcommittee's desire during the second hearing to receive testimony from the public and interested organizations wishing to comment on the Advisory Council's recommendations.

The Subcommittee has invited the Congressional Budget Office to provide its latest estimates of the status of the medicare trust funds. Since these estimates were last published, CBO has completed its midyear review of budget projections. In addition, the Congress has enacted legislative changes to the medicare program. Both of these actions will affect medicare outlay projections.

The Subcommittee also wishes to receive testimony on H.R. 4870, the "Medicare Solvency and Health Care Financing Reform Act of 1984," introduced by the Honorable Richard A. Gephardt (D., Mo.). [A companion bill, S. 2424, was introduced in the Senate by the Honorable Edward M. Kennedy (D., Mass.)].

The Subcommittee also intends to receive testimony on other proposals and recommendations addressing the medicare financing crisis, health care cost control or reform of the health care system, such as H.R. 3884, the "Health Service Act," introduced by the Honorable Ronald V. Dellums (D., Calif.).

A variety of other proposals reforming medicare have been introduced. Among them are proposals to provide supplemental medicare coverage through the medicare program with the beneficiary paying a premium for the additional cost of the benefits. The Subcommittee would also like to hear from witnesses having views on these proposals.

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD

Individuals and organizations interested in presenting oral testimony before the Subcommittee must submit their requests to be heard by telephone to Harriett Lawler [(202) 225-3627] no later than noon on Monday, September 10, 1984, to be followed by a formal written request to John J. Salmon, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. Notification to those scheduled to appear will be made by telephone as soon as possible after the filing deadline.

In view of the limited time available to hear witnesses, the Committee may not be able to accommodate all requests to be heard. Those persons and organizations not scheduled for an oral appearance will be encouraged to submit written statements for the record of the hearing. All persons requesting to be heard, whether they are scheduled for oral testimony or not, will be notified as soon as possible after the filing deadline.

It is urged that persons and organizations having a common position make every effort to designate one spokesman to represent them in order for the Committee to hear as many points of view as possible. Time for oral presentations will be strictly limited with the understanding that a more detailed statement may be included in the printed record of the hearing. This process will afford more time for members to question witnesses. In addition, witnesses may be grouped into panels with strict time limitations for each panelist.

In order to assure the most productive use of the limited amount of time available to question witnesses, witnesses scheduled to appear before the Subcommittee are required to submit 100 copies of their prepared statements to the main Committee Office, Room 1102 Longworth House Office Building, at least 24 hours in advance of their scheduled appearances.

Each statement to be presented to the Subcommittee or any written statement submitted for the record must contain the following information:

1. The name, full address, and capacity in which the witness will appear (as well as a telephone number where the witness or a designated representative may be reached);
2. A list of any clients or persons, or any organization for whom the witness appears; and
3. A topical outline or summary of comments and recommendations.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearing, six copies are required and may be submitted by the close of business Friday, September 28, 1984, to John J. Salmon, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, Room 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements for the printed record may be furnished for distribution to the press and public if supplied to the Committee office before the hearing begins.

Chairman JACOBS. Our hearing today is concerned with the Medicare financing crisis and recommendations for reforms. The Chair commends the various witnesses who have chosen to participate in this hearing this morning, perhaps to illustrate to the general public the kind of absolute tragedy which could develop in the Medicare Program by the time this decade is out.

Our leading witness in the Medicare area, on behalf of the taxpayers and beneficiaries, is the Honorable Edward Kennedy of Massachusetts. Senator Kennedy, we are pleased to welcome you and ask you to proceed in your own way.

STATEMENT OF HON. EDWARD M. KENNEDY, A U.S. SENATOR FROM THE STATE OF MASSACHUSETTS

Senator KENNEDY. Thank you very much, Mr. Chairman.

First of all, I want to express on behalf of myself and the 6.5 million citizens of the Commonwealth of Massachusetts the great sense of appreciation for your holding these hearings today. Today is Senior Health Action Day. And across this country there will be

meetings of concerned citizens to focus on the key issues of health care for the future. By this meeting here today, we hope to once again bring to the Congress of the United States the focus and attention on what I consider to be the overriding domestic issue in the next Congress of the United States.

Mr. Chairman, as you have done on so many issues, you are preparing this committee, and hopefully the Congress, to take the kind of steps which are going to be necessary in order to protect our senior citizens and protect Medicare and to move us on to a path of sensible, responsible, compassionate health care policy for the 1980's.

Mr. Chairman, we have a proposal to deal with this problem that Congressman Gephardt and I have worked long and hard with you and other members of this committee such as Congressman Shannon and others. In making that proposal, I think it is important to put this whole issue into some perspective.

The kinds of recommendations we have made I think are important, they are serious, they are responsible, they address the issue, but I think it is important for the American people to understand first of all the nature and gravity of the problem that we are facing. With your permission, I will file my statement with the record and will also include in the report a smaller edition of the charts you see here today.

But if I could, I would like to review these charts with the committee briefly this morning. Mr. Chairman, over on this first chart we see the flow line with regard to the Medicare trust fund through the end of the century. It reflects that, by the year 2005, we will have a $1 trillion deficit in the Medicare trust fund. This Congress, this country, has been concerned in the past few years about the deficit of the Social Security System, but the flow line with respect to Medicare really makes the Social Security deficit look trivial.

This next chart, Mr. Chairman, shows what the average elderly patient is paying for health care, $1 out of $7 of income. This is a matter of enormous concern to elderly people as they are paying more and more out of pocket to meet their health care needs. Elderly people are concerned about the amount they must pay today; they are concerned about how this line is going up, they are concerned about the cuts that have been proposed by the administration and they understand, Mr. Chairman, that by the year 2000 we are talking about some $4,600 out-of-pocket expenses for elderly people. This is something that they understand and will be an enormous burden for our senior citizens.

This next chart, Mr. Chairman, compares the rate of inflation for other items in our society and to what has happened in health care. You can see the dramatic increase in health care inflation over the Consumer Price Index in the 1960 through present period. The per capita cost of health care has gone up dramatically, four times as much as the Consumer Price Index.

As we look at these projections of the Medicare trust fund deficit, there may be some dispute about the dollar value of this figure, whether it is $1 trillion in deficit or whether it is $800 million, but you can't get away from the fact that we are talking about a large deficit, and first we are talking about bankruptcy.

The President's program, Mr. Chairman, is some $31 billion in Medicare cuts over a period of 5 years. President Reagan has said that if anyone could find any reduction in Medicare benefits that his temperature would go up. Well, he ought to read his own proposals to this committee and to Congress, because he has signed into law or proposed some $31 billion in benefit cuts, reductions of coverage or increases in premiums, over the period of the next 5 years. That is $1,000 reduction in coverage for the elderly people over the next 5 years. That is included in our written testimony.

By contrast, Mr. Chairman, with our proposal there are no reductions in coverage for the elderly. This compares to the President's proposals for $1,000 in cuts and no significant improvement in Medicare solvency.

I imagine in the House of Representatives, we call this proposal Gephardt-Kennedy; over in the Senate, we call it Kennedy-Gephardt. If this bill is enacted, we will create a surplus in Medicare without any reduction in benefits, as this chart shows. I think it is probably appropriate to view both of these charts in tandem.

If nothing is done, Medicare is some trillion dollars in deficit. If we adopt the Gephardt-Kennedy proposal, we will see that we will have some $165 billion in surplus by the year 2005 without requiring additional payments of premiums and without reducing the benefits themselves.

Mr. Chairman, if this program is implemented, there is also a reduction in the Federal budget deficit, some $30 billion in reduced Federal expenditures over the period between 1985 and 1989. Our proposal is an important contribution to deficit reduction. Given the size of the deficits we are facing today, this is an important contribution of our program.

This next chart, Mr. Chairman, indicates the savings for non-Medicare users. Between 1985 and 1989, the consumers of this country, the non-Medicare consumers of this country, will save some $74 billion. The impact of our proposal, Mr. Chairman, consumers will save $74 billion, deficit reduction of $30 billion and a surplus in the Medicare trust fund.

I might mention at this point that the administration has appointed a commission to review how to deal with the Medicare crisis, the Bowen Commission. This Commission made a series of recommendations. We have had responsible administration officials before our Senate Labor and Human Resources Committee, and they will not tell us today what their response is to the Bowen Commission's recommendations on how to deal with the Medicare crisis. They say they will tell us after the election.

Well, that basically is asking the American people to buy a pig in a poke. The track record of this administration is a reduction in Medicare benefits and an increase in Medicare premiums that have been requested and some unfortunately passed the Senate of the United States over the objection of a number of us. We know very well what the administration program will be for senior citizens, and that is why the elderly people in this country are gathered together today to demand responsible action on Medicare.

Finally, Mr. Chairman, in our proposal, just very briefly, and I know Congressman Gephardt will expand on these, basically what we are proposing is provide a prospective budget for hospitaliza-

tion, for in-hospital doctors' fees, and incentives to reduce unnecessary admissions. These provisions apply to our whole medical care system, not just Medicare, so that we can get at the underlying cause of Medicare's problems—excessive inflation in the cost of Medicare.

Our proposal provides maximum flexibility to States to work out whatever programs they would like, including features of competition, that can reach the general guidelines established in the legislation. There are incentives to increase competition included in the legislation, and there are requirements for assuming that payments under the Medicare Program are for the hospital and physician care payments in full, so that our senior citizens are protected from being charged more than Medicare's recognized fees.

Mr. Chairman, we offer this program realizing that the committee process, this committee and others who have a knowledge and understanding and awareness of this issue, will review the legislation and be able to examine it in closer detail. They will be able to make recommendations.

We do not suggest this legislation is perfect and will not be further reformed, but what we do say is that this is a path which will ensure the integrity of the Medicare system, ensure senior citizens of the Nation that there will be no reduction in vitally needed Medicare benefits and ensure all our citizens that we will keep health care affordable. And I think adoption of this legislation will ensure that, at long last, we are beginning on a sensible and responsible path toward recognizing that health care in our society should not be considered a privilege, but should be considered a right.

Thank you.

[The prepared statement follows:]

STATEMENT OF HON. EDWARD M. KENNEDY, A U.S. SENATOR FROM THE STATE OF MASSACHUSETTS

I am delighted to have the opportunity to appear before you on the vitally important subject of Medicare.

Today is Senior Health Action Day. Under the auspices of the National Council of Senior Citizens, elderly Americans will be holding rallies and meetings at over one hundred locations around the country. They will express their strong conviction that the key senior issue of the 1984 election is the preservation of Medicare and the control of health care cost inflation.

The concern our senior citizens feel is not misplaced. Older Americans have a special vulnerability to the high cost of health care. Prior to the enactment of Medicare in 1965, serious illness threatened virtually every older American with the possibility of the loss of a lifetime of savings. Even today, as a result of two decades of excessive health care cost inflation and gaps in Medicare protection, senior citizens must spend an average of one dollar in every seven of their limited incomes to purchase the health care they need.

As if the crushing weight of the medical costs that Medicare does not finance were not a sufficient burden for our senior citizens to bear, the Medicare program itself is in grave trouble. Over the next two decades, Medicare faces a cumulative deficit of approximately one trillion dollars. According to the latest report of the Medicare Trust Board of Trustees, Medicare is likely to be bankrupt by 1991. Eliminating that trillion dollar deficit by cutting benefits would require benefit reductions of approximately one third. Eliminating that trillion dollar deficit by raising taxes would require increasing the Medicare share of the payroll tax by almost 50 percent.

Now there is nothing magic about the exact value of these numbers. Estimates change from year to year; the CBO has a different baseline estimate than the Medicare actuaries. The true bankruptcy date may be 1989 or 1993; the deficit by 2005

may be 1.2 billion or $800 million. The key point is that everyone agrees that bankruptcy is not far off and the scope of the problem is very large.

Senior citizens look at the amount of money that must spend today to purchase the medical care they need and they feel pain. They look at the projections of the future of the Medicare program on which they are so dependent and they are fearful. And they look at what the current Administration has offered them the tone of the budget debates over the last few years and they feel more than pain and more than fear; they feel a deep and justified anger.

The Reagan record on Medicare is truly shameful, so shameful that this Administration will try to duck and weave and bob on this issue all the way to Election Day. The President recently gave an address to a group of the elderly. He said, and I quote, "There are those who claim that we cut Social Security and Medicare benefits, and I have to tell you, whenever I hear that, it sort of touches my temperature control. Nothing could be further from the truth."

The sad fact is that if you add together the Medicare benefit cuts and premium increases supported and signed into law by this Administration and the further benefit cuts and premium increases recommended by this Administration in its 1984 and 1985 budgets, they come to a total of $31 billion over the next five years. That is a total of $1,000 less Medicare for every elderly and disabled person in America. My question is this: Mr. President, how high did your temperature rise when you approved those budget cuts? And do you really think the American people are going to let you get away with this?

The cause of the massive Medicare deficit is not benefits that are too generous or payroll taxes that are too low, but the excessive inflation in the cost of health care that infects all of American medicine. Between 1960 and today, the American people have seen their per capita health costs increase 1,000 percent, four times as much as the cost of everything else in our economy.

The sources of this exponential increase in health care costs are widely recognized. Americans generally pay for health care through a system of open-ended, cost-plus, third-party reimbursement that encourages waste and provides no incentives to deliver care efficiently. By contrast, where health care providers face economic incentives to deliver care efficiently, major savings have been achieved. Health maintenance organizations—which must provide complete medical care for their members within a fixed budget—generally provide high quality medical care at a cost 20-40 percent less than conventional fee for service medicine. In States that provide incentives for hospitals to deliver care efficiently by setting budgets in advance, hospital cost increases have averaged three to four percent a year less than the national average.

The excessive inflation in health care not only jeopardizes the future of Medicare and burdens our senior citizens, it threatens to price health care out of the reach of every American citizen. The escalating cost of financing employment-based health insurance benefits weakens American business struggling to compete in world markets. It puts every American worker under pressure to trade hard-won health benefits for needed money wages every time his Union sits down at the bargaining table. And it makes the goal of universal health insurance for the 30 million Americans without any health coverage at all even harder to reach.

The Reagan Administration and the Republican Party have offered no solution to the crisis of Medicare. Indeed, they stated at hearings before our Senate Committee on Labor and Human Resources that they will not offer any plan—until after the Election. The Administration's hand-picked Advisory Council on Social Security has offered a harsh and unreasonable proposal to raise the age of medicare eligibility to 67, to impose higher premiums and co-payments, on Medicare beneficiaries to tax health insurance benefits, and to shift costs to the private sector. Ironically, those draconian proposals would only delay Medicare bankruptcy rather than solving it, because they would do nothing to slow the underlying health care cost inflation that is the basis of Medicare's difficulties.

While the Advisory Council's recommendations are fatally flawed, they at least are a serious proposal. What is the Administration's position on the recommendations of their own Advisory Council? They won't say—until after the Election.

I do not believe that a "Secret Plan" is an acceptable position for any Administration to take on an issue that is absolutely vital to the quality of life of 30 million aged and disabled Americans.

The fact is, there is a plan on the table that is not a secret. When I appeared before this Committee on September 28 of last year, I indicated that I had a Medicare Rescue Plan under development and outlined a set of principles on which a Medicare Rescue Plan should be based. In early March of this year Congressman

Richard Gephardt and I introduced this proposal as S. 2424 in the Senate and H.R. 4870 in the House. Vice President Mondale has proposed a similar plan.

Our plan has several key features. First, it sets revenue limits for all in-patient hospital costs, not just those hospital costs paid by Medicare. The limit we set is the one Congress has already said is reasonable for the Medicare program—market basket plus one percent per admission. By setting a limit for all costs, our plan provides a solution to the underlying problem of health care cost inflation that hurts all Americans and is at the root of Medicare's current difficulties.

Second, our plan includes in-patient services provided by physicians within those revenue limits. Physicians order or control seventy percent of all hospital costs. The increase in Medicare physician expenditures last year was 16 percent. The worst inflation in the whole health sector. No program that does not limit these cost increases and provide incentives for physicians to deliver care cost-effectively can be successful.

Third, our plan provides incentives to deliver care in less costly out-patient settings where medically appropriate. One of the key factors driving up Medicare costs has been hospital admissions increases far outstripping the increase in the Medicare population. Excessive hospitalization is neither good medical practice nor cost effective.

Fourth, our plan is a State-based system. It is not a "Washington knows best scheme." Health care services are delivered locally, and it is at the local level that the planning decisions essential to the best delivery of care should be made. Moreover, there is no one best way to control health care costs. There are ten States that have legislated relatively comprehensive systems to regulate hospital costs, and each one of them is different. Accordingly, our plan encourages States to set up their own cost control system. The State system can be mandatory, voluntary, or competition-based. As long as the State system meets the revenue targets contained in the bill and certain other broad requirements designed to ensure protection of the poor and fair treatment of all purchasers of care, the State can control hospital costs in any way it chooses.

If a State fails to act, however, a back-up Federal system will go into place until a State chooses to implement a plan. Control of health care costs and preservation of Medicare is a national responsibility. The Federal government must be prepared to act as a last resort.

Last, our plan encourages the growth of cost-effective HMO's as well as other market-oriented solutions to the health care cost problem. A mix of regulatory and competitive approaches is far more effective than a rigid reliance on one or the other method.

Finally, our plan mandates Medicare assignment for all Part B services. Elderly people should not asked to pay higher fees for physician services than Medicare recognizes as measurable.

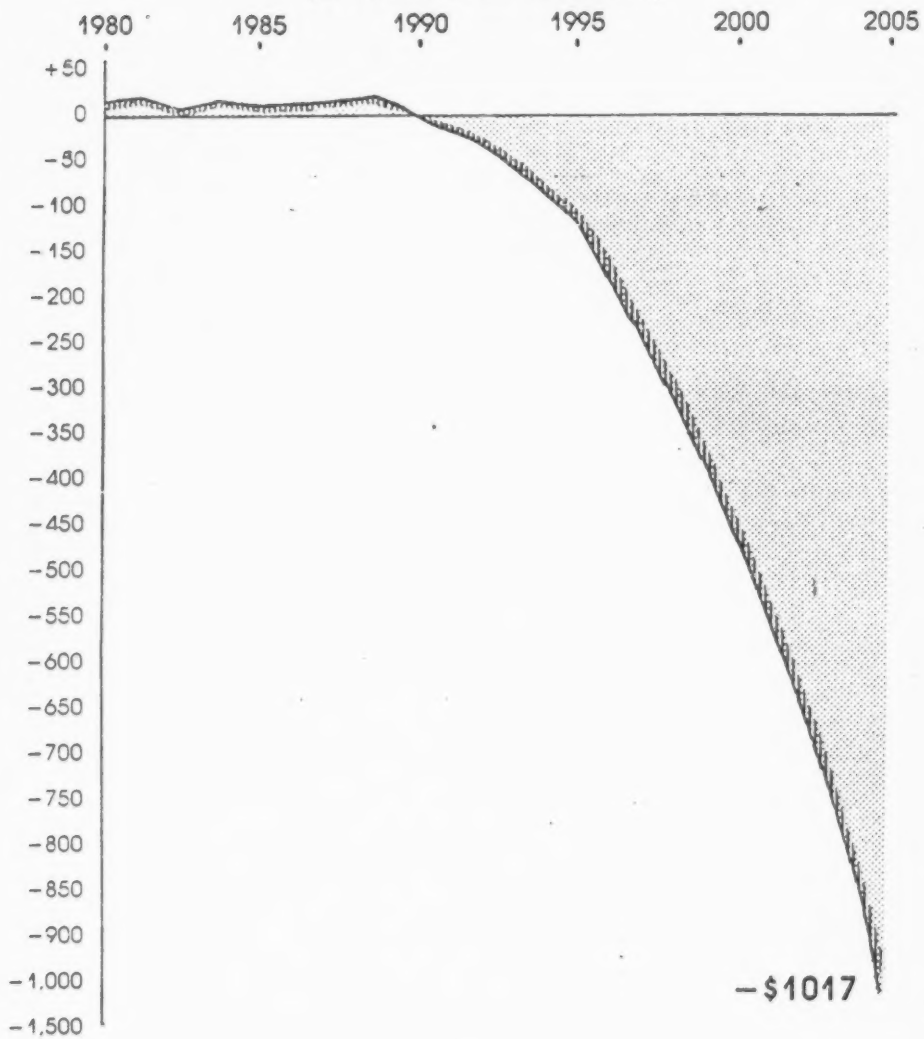
Our plan has been endorsed by a broad coalition of groups concerned about the future of Medicare, including the American Association of Retired Persons, the National Council of Senior Citizens, the Save Our Security Coalition, the AFL-CIO, and consumers, religious, and civil rights groups.

Enactment of our plan will change the worsening trillion dollar Medicare deficit to an improving $160 billion surplus and will assure Medicare solvency in every year of the projection period. It will do so without reducing Medicare benefits or raising Medicare taxes. It will reduce the Federal deficit approximately $30 billion over the next five years. and it will save the private sector an even greater amount.

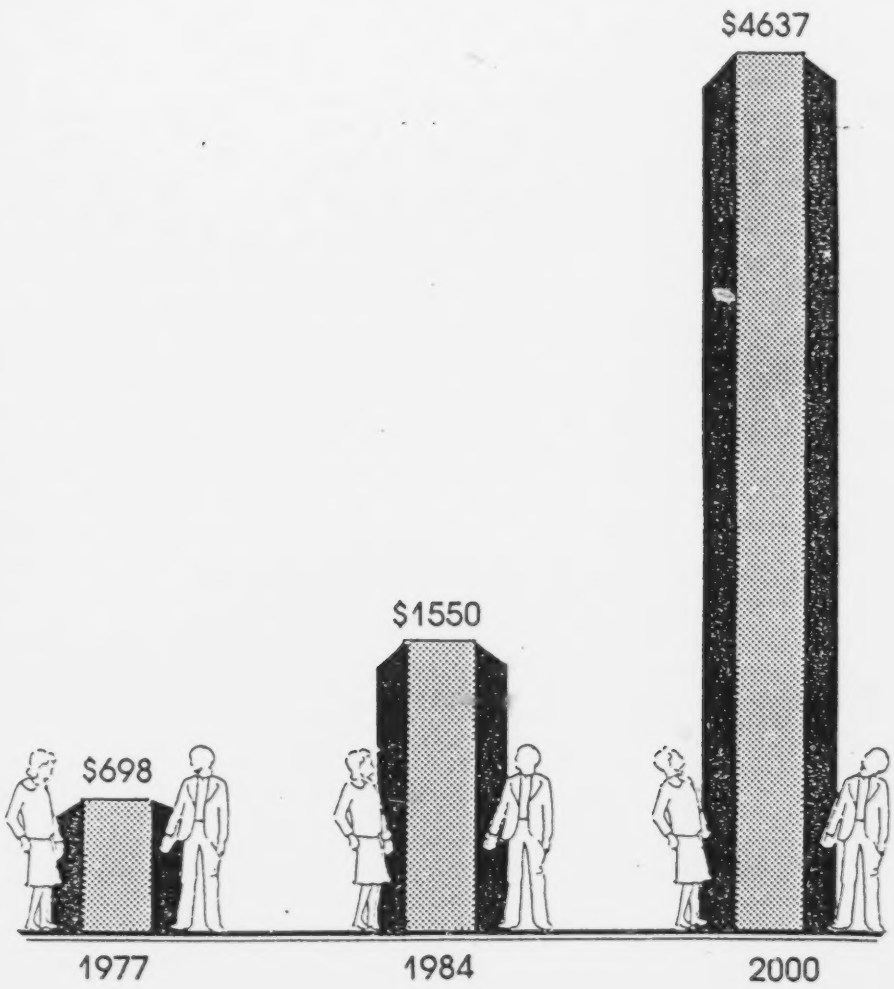
I urge this Committee to give H.R. 4870 prompt and favorable consideration. Our nation's senior citizens deserve to know that Medicare's future is secure and all our nation's consumers deserve relief from high health care costs. We do not want to enter another reconciliation next year with savage Medicare benefit cuts on the table and no serious alternative that will both reduce excessive medical cost increases and protect beneficiaries.

MEDICARE TRUST FUND BALANCE UNDER CURRENT LAW

(IN BILLIONS OF DOLLARS)

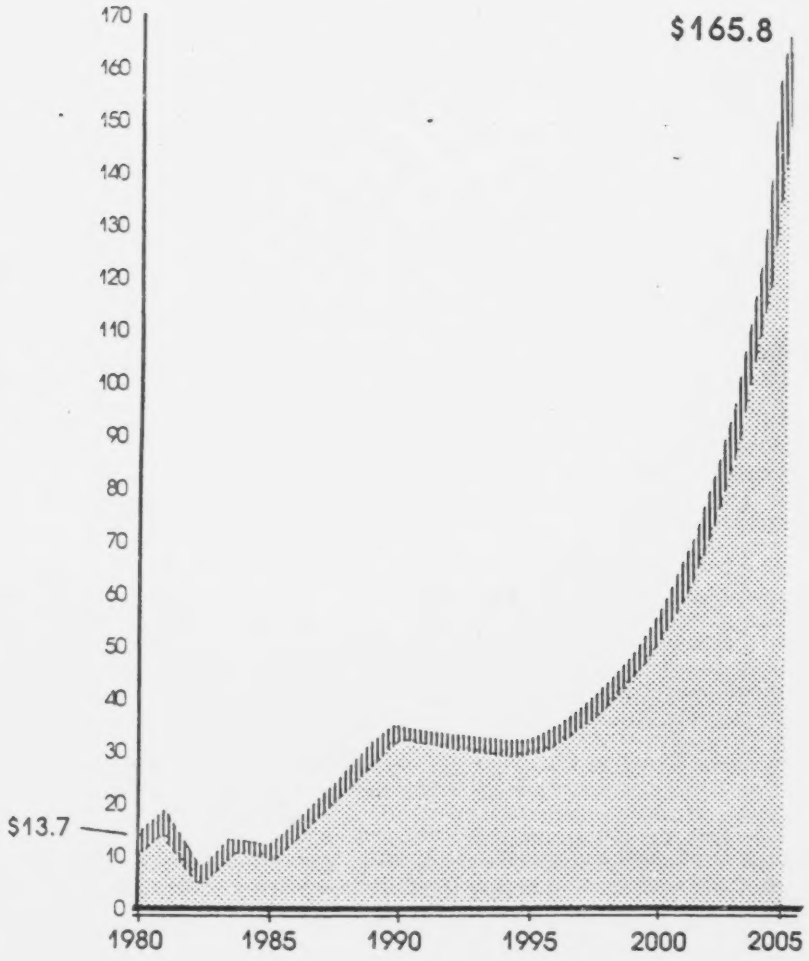


AVERAGE ELDERLY PAYMENT FOR HEALTH CARE

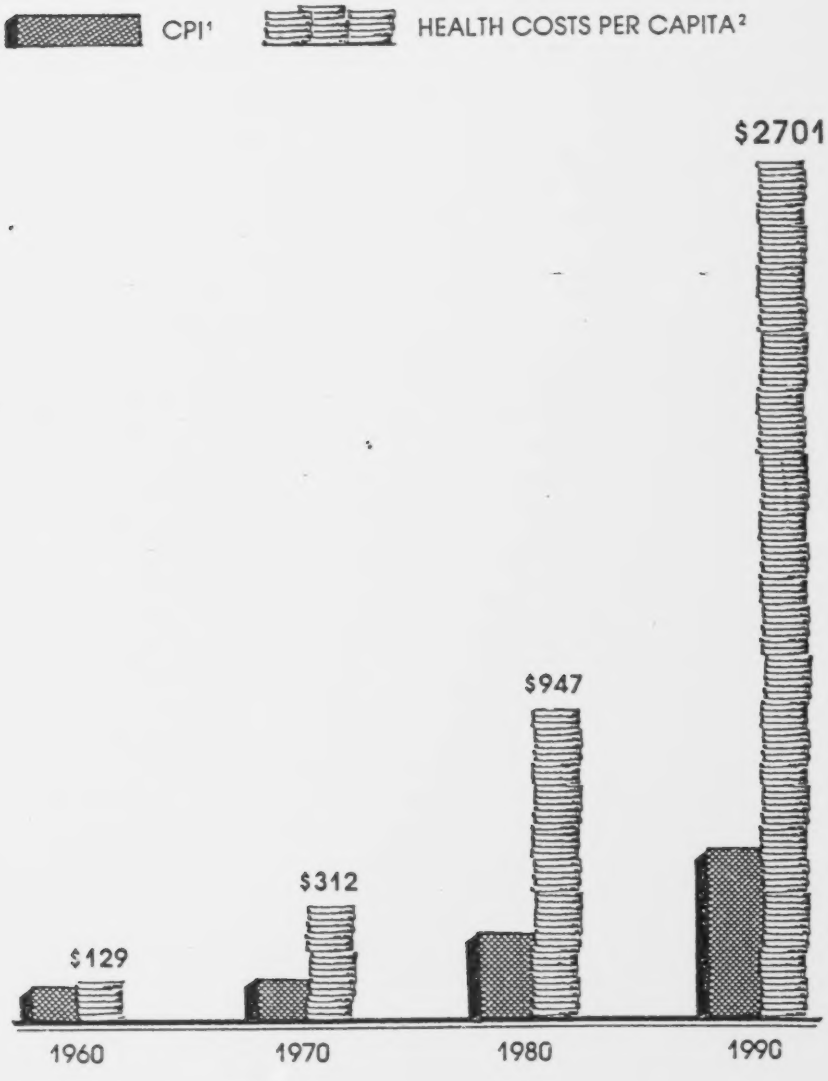


MEDICARE TRUST FUND BALANCE UNDER KENNEDY - GEPHARDT

(IN BILLIONS OF DOLLARS)



HEALTH COST INFLATION

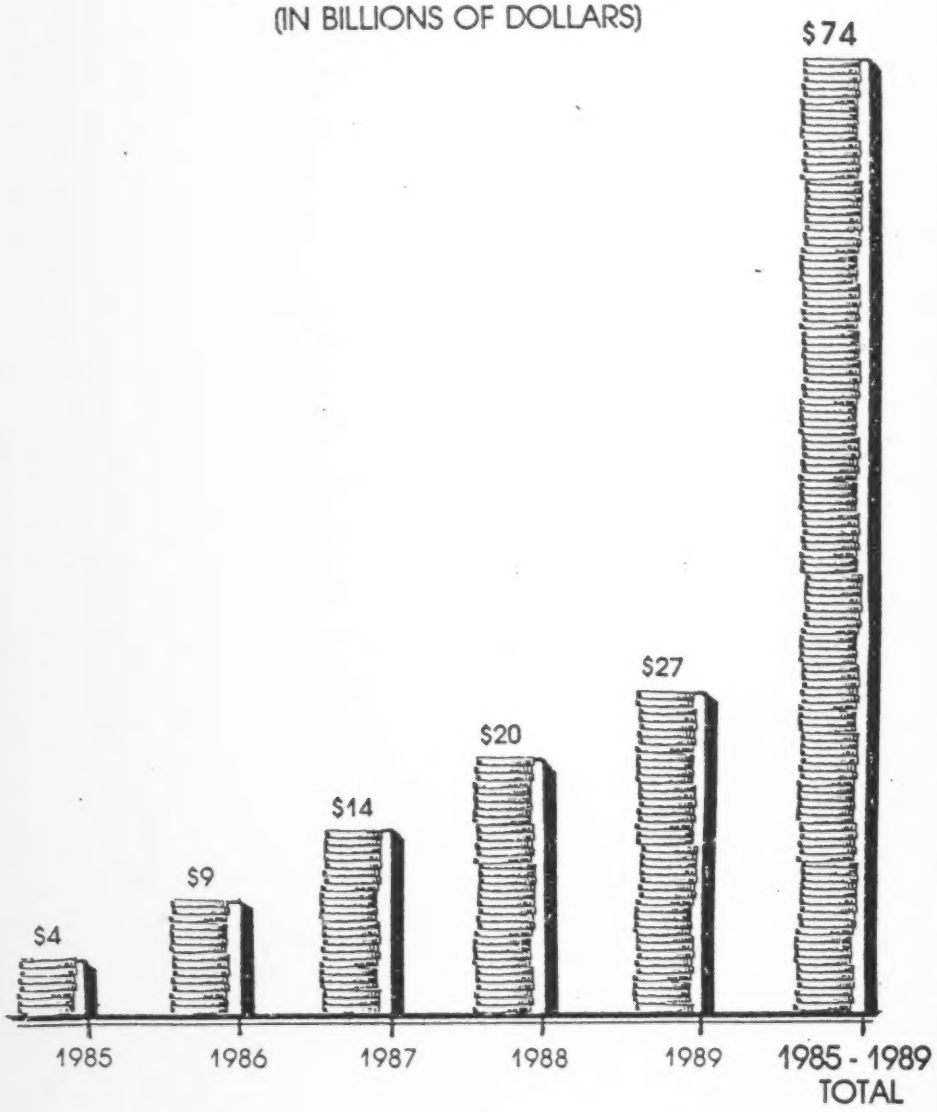


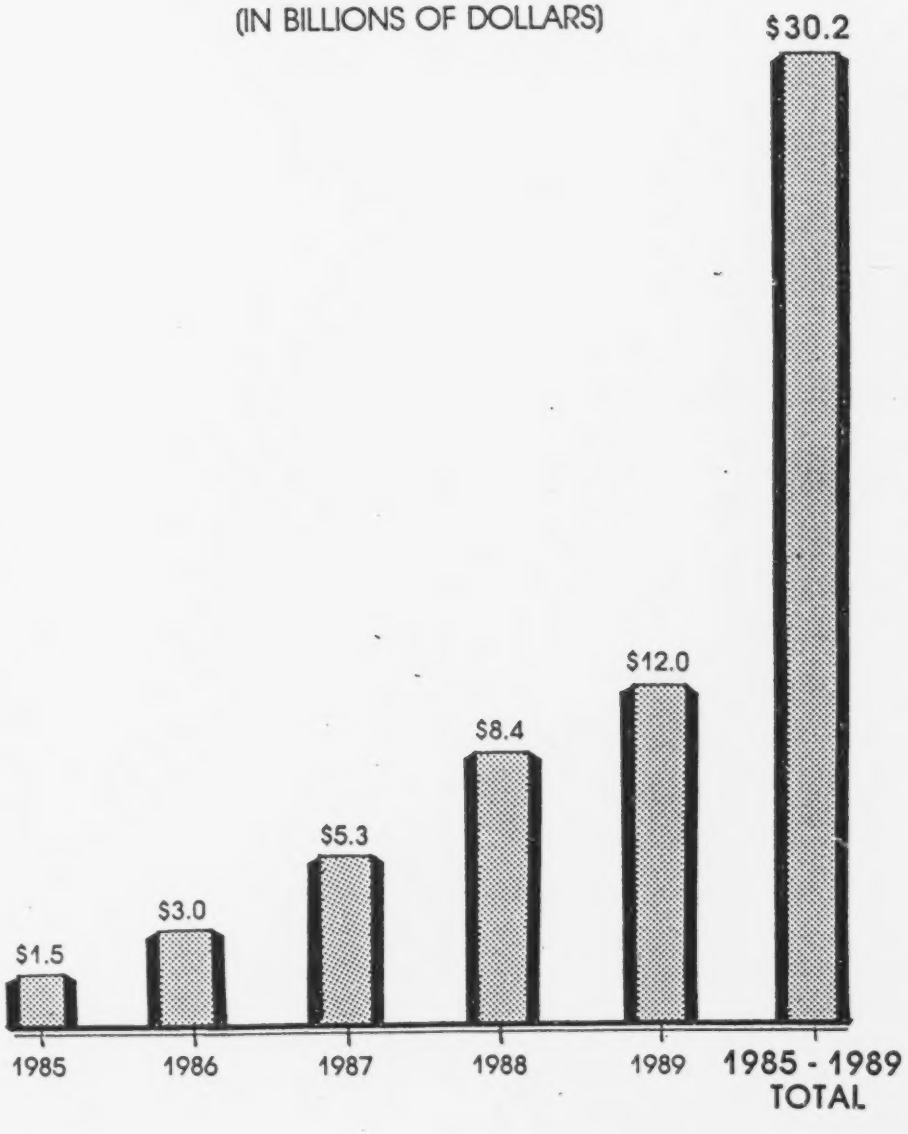
[1] In Per Cent of 1960 Base

[2] In Dollars

KENNEDY - GEPHARDT: PRIVATE SECTOR SAVINGS

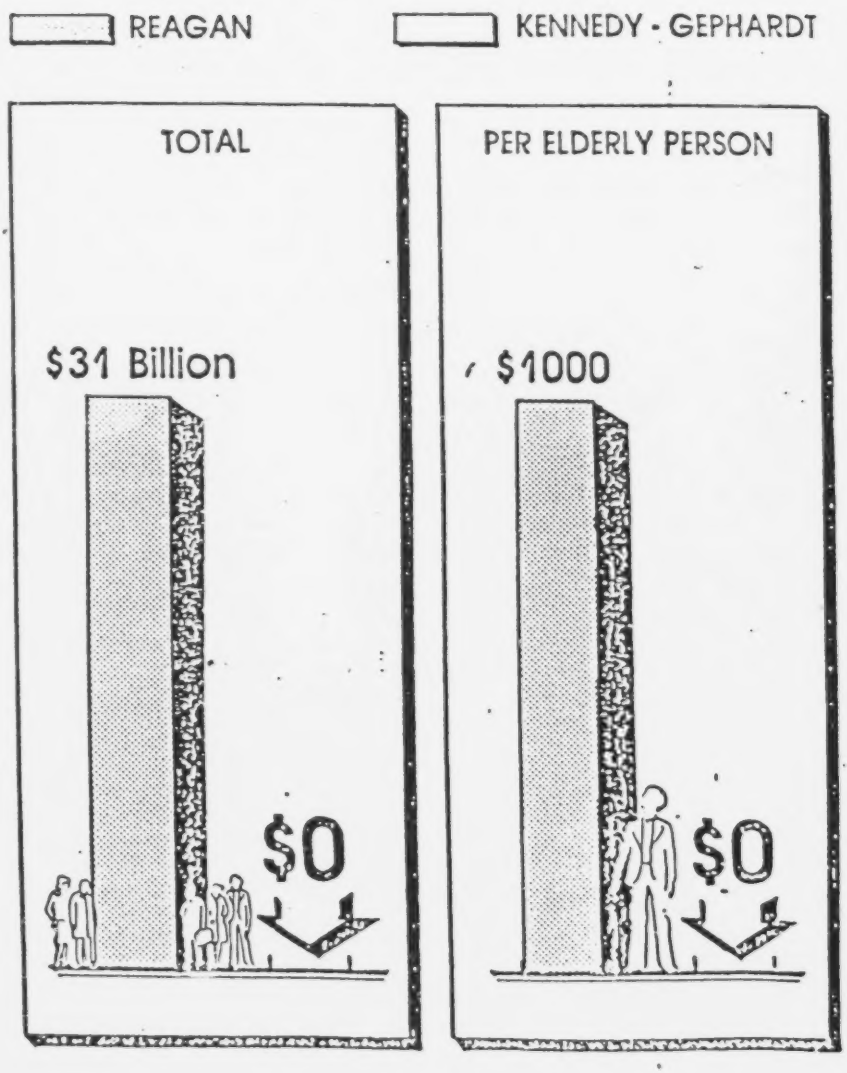
(IN BILLIONS OF DOLLARS)




KENNEDY - GEPHARDT:
DEFICIT REDUCTION
(IN BILLIONS OF DOLLARS)
$1.5
$3.0
$5.3
$8.4
$12.0
$30.2
1985
1986
1987
1988
1989
1985 - 1989
TOTAL

41-179 O - 85 - 2

CUTS IN MEDICARE BENEFITS



Chairman JACOBS. Thank you, Senator.

Mr. Duncan.

Mr. DUNCAN. Thank you, Mr. Chairman.

I want to thank the Senator for his appearance. You indicated the administration was changing the Medicare provisions in law. I have been on this committee 16 years, and I have never known anything that an administration could do, regardless of whether it was Democrat or Republican, unless it first cleared this committee which is controlled by the majority party by about two to one. Do you not agree that the administration can't move a comma or change a figure unless it first clears this committee?

Senator KENNEDY. Senator, you are too knowledgeable and wise to really believe that. All you have to look at is what the Senate Finance Committee did in terms of the last proposal before the Senate of the United States, some $10 billion reductions in benefits and increases in premiums that were accepted on the floor of the U.S. Senate, thankfully that reduction, and it was supported by the administration——

Mr. DUNCAN. It had to clear this committee, also.

Senator KENNEDY. If I could just continue in response to the question.

This House under the Democrats refused to go along with that, refused to cut the Medicare Program, as you well remember.

I am glad you insist on bringing this up. This committee, under the Democrats, refused to go along with the unfair cuts. And the Republican Senate Finance Committee proposed $10 billion, and as a result of the conference, it came out about $2.3 billion.

I wish it had not. I made a series of recommendations that we could have made that money up in other ways, minimum corporate tax, for example, we could have recovered about $10 or $11 billion over the period of the next 3 years. So I think it is important to understand who is making these requests and who is cutting Medicare, and I think any fair reading of the debate in the Senate and in the House would quite clearly reflect where these cuts came.

Final point, when I offered two amendments on the floor of the U.S. Senate to reduce the cuts $10 billion, only two Republicans, Congressman, only one Republican, in that whole body, which is controlled by the Republicans, supported both House amendments.

Mr. DUNCAN. I think the American people are smart enough to know, that the final result was worked out in conference, during which time the Democrat conferees, to their credit, agreed to the legislation.

Senator KENNEDY. That is right, thankfully they were able to reduce the draconian cuts of the Senate.

Mr. DUNCAN. The House section of the conference is always controlled by the good Democrats of this committee and so you must agree that the final result, regardless of what is suggested or what the Senate did here and there, the final result was a compromise or agreement by the conference from the House and the Senate. I think most people understand that.

Thank you, Mr. Chairman.

Chairman JACOBS. Well, I guess I should say for the record that there is nobody in the House of Representatives I admire more or like more than my colleague from Tennessee, but having been a

member of that conference committee, I will say for the record that the House Ways and Means Committee had one guideline in making reductions in the Medicare trust fund expenditures this year, and that was that not one hair on the head of one Medicare beneficiary would be touched.

We kept faith with that resolution, and when we went to the conference, obviously you have a choice, either you don't have a bill at all or you have to make some compromise with those who think diametrically opposite to the way you think, and that compromise was made.

I might add that in the conference, members of this committee from minority side, who were members of the conference, one in particular, stated quite clearly that the reason additional cuts were requested by the administration and were necessary, he said, was because of additional military spending, the other body, the U.S. Senate, had voted, thus bringing into question—and I said it myself, and I will say it for the record now—that what obligation this country has to the dictators of this Earth who are destroying their own countries and what obligations this Government has to the retirees that helped build this one.

So it seems to me, Senator, you might want to comment on this, that there are commonly three factors people consider in the Medicare Program: the taxpayers, the beneficiaries and the providers. But I submit that very realistically there is a fourth factor, and that is the priorities of the U.S. Government, how much we will spend killing people in other countries and how much we will spend curing people in this country.

Perhaps you would like to comment.

Senator KENNEDY. Well, I think you have stated it well, Mr. Chairman, as always, and I think that this is one of the reasons that this issue be debated and discussed during the course of the campaign, because I think you can't get away from the fact that this Medicare trust fund is in deep crisis and the American people are entitled to know before the election what those who have some responsibility for this system are going to do after the election.

I have been enormously troubled by the fact that the responsible officials within the administration have refused to come up with a solution or recommendation. What we can only assume is that they will follow the path of the past which is clearly a reduction in coverage, and an increase in premiums. If that is not their position, they ought to be forthcoming in telling us what it is. I think the American people are entitled to it, and hopefully we can, prior to the time of the election, give them at least some indication as to what alternatives are available to them.

Chairman JACOBS. I will tell you, we have an old hoosier philosopher named Abe Martin who said there is always plenty of money for everything but the necessities. That might touch on priorities to which we are referring in the Government.

Well, is there rebuttal or further questions?

Mr. DUNCAN. No further questions, Mr. Chairman. Thank you.

Chairman JACOBS. In that case, we thank you for your contribution to the record.

Senator KENNEDY. Thank you, Mr. Chairman.

Chairman JACOBS. I believe Representative Stark may be on deck here. He will be either instead of or in addition to Congressman Gephardt. I understand in addition to Congressman Gephardt. Mr. Stark of California cannot be welcomed to the committee because he is already a member; however, you may proceed.

STATEMENT OF HON. FORTNEY H. (PETE) STARK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. STARK. Thank you, Mr. Chairman.

I want to, at the risk of oversimplifying your job, testify in behalf of H.R. 3513, which in its utter simplicity takes an 8-cent increase in excise tax on cigarettes adjusted annually to reflect increases in the cost of living, and earmarks it for Medicare.

It is a user fee. I would ask, by way of unanimous consent, that my full prepared remarks be placed in the record.

Chairman JACOBS. Without objection.

Mr. STARK. I would guess or bet that 75 percent of the American public would vote for this. I would imagine that there is no serious scientific debate that links cigarette smoking directly to $3 billion or $4 billion a year in medical costs in this country. I would suspect that even smokers would be in the majority side of this issue. And, like our President, I have a secret plan for getting the tobacco States to support this legislation once your committee has agreed to mark it up.

I think that, in all seriousness, the only opposition to this comes out of a well-organized, well-meaning tobacco lobby representing both those thousands of Americans who grow the leaf and those fewer Americans who reap the profits of converting that into the deadly cigarette.

I think that it is time to recognize that it is a block, it has been an effective block, and the necessary amendments to this type of legislation will be needed to see it pass through. Quite basically, it would mean earmarking some additional tax for a trust fund that would be used to help the farmers in any painful conversion or indeed would perhaps fund the loan program. And once we recognize that our problems in this are not anything but that type of political problem, we have an overwhelming majority, I think, of House Members who would support it.

I would hope that the committee, in the next year, in looking for revenue to fund the ever-increasing medical costs in this country, would look seriously at the user tax. And I think this is probably a field that stands alone by having so much documented evidence relating the usage directly to the health costs.

It seems to me that once in place, it would probably not disrupt our economy, nor would it disrupt our constituents. And I would urge the committee to seriously consider it and see if we could put together a coalition that would include the distinguished gentleman from Tennessee to support this type of tax.

[The prepared statement follows:]

STATEMENT OF HON. FORTNEY H. (PETE) STARK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Chairman, thank you for allowing me to testify today on possible solutions to the impending financial problem Medicare will face in the next few years.

In the name of good health, both fiscally for Medicare and physically for Americans, I urge the Committee to consider my bill HR 3513. This legislation would earmark for the Medicare Health Insurance Trust Fund (HI) an 8 cent increase in the excise tax for cigarettes and adjust this increase annually to reflect increases in the cost of living.

The premise of this legislation is simple. It is estimated that Medicare and Medicaid spend nearly $4 billion annually for the treatment of smoking-related diseases. A user fee in the form of an excise tax on cigarettes, as outlined in my bill, would raise roughly $3 billion each year for Medicare. In other words, HR 3513 would mean that those who smoke would be paying the lion's share of their own smoke-related health care costs.

Not only is this legislation cost effective, it is supported by the majority of the American public. Seventy-seven percent answered affirmatively when asked if they favored an increase in the cigarette excise tax; this was part of a national poll taken last January by Yankelovich, Skelly and White to determine the public's views on alternate ways to reduce the federal deficit. Even more importantly, the Yankelovich survey demonstrates that smokers as well as non-smokers are not opposed to this measure.

Since smokers are aware of the health risks of smoking and can actually prevent them, it makes sense that they begin to pay a greater share of their extra health costs.

Over 300,000 Americans will die this year as a result of smoking-related illness. Enactment of this legislation would discourage smoking and would compensate the government and the Medicare Trust fund for the massive financial burden generated by the 33 percent of the American people who choose to smoke.

I hope the Committee will seriously consider this long overdue effort to increase the cigarette excise tax and earmark for the Medicare Trust fund. In so doing, you will be attacking America's largest preventable cause of death and helping to keep Medicare sound and solvent for us all.

Chairman JACOBS. The distinguished gentleman from Tennessee.

Mr. DUNCAN. I have no questions. Thank you. The gentleman always explains everything so well that I don't have to ask.

Mr. STARK. I thank the distinguished ranking member for his forebearance.

Chairman JACOBS. I suppose a person who smokes most heavily is the best candidate for lung cancer.

Would that meet your agreement?

Mr. STARK. I would suppose a person who smokes heavily is a candidate for a host of medical problems. And this morning they decided that it might very well impede the healing of ulcers, stomach ulcers; it might be heart disease; it might be emphysema; cancer of the mouth; it might be lung cancer; it might cause egregious gum or dental problems.

Chairman JACOBS. Bad breath.

Mr. STARK. I suppose that is in the nose of the inhaler. I would not be able to judge that.

You are talking to a reformed smoker, and those are the worst kind, as they say.

Chairman JACOBS. That could be a burden on the doctor treating the patient, I would think. So it would have to be a factor.

The point is that in terms of the user's fee, as you put it, the person who uses the substance the most and was most likely then statistically to be a burden on the trust fund, would make the greater contribution to the fund.

Mr. STARK. Precisely.

Chairman JACOBS. I might say for the record, I have just been handed a statistic—I guess it comes from somewhere—that lung cancer in the last year or so has surpassed breast cancer as a lead-

ing cause of mortality among women between the ages of 63 and 74.

Pete, on the same subject of the user's fee or relationship between your own activities and what it costs the taxpayers on the Medicare Program, it seems to me there are some insurance programs which pay a higher damage claim if the insured was wearing a seatbelt at the time of an automobile collision in which the insured was injured.

I have to admit that somewhere in the inner reaches of my mind I have been wondering what would happen if the Medicare Program had such an adjustment so that the Medicare beneficiary who drove his or her car without a seatbelt and a collision occurred, and the person got the head bashed in or something, that the coverage would not be quite so high. Do you suppose that would be any incentive for the ounce of prevention which could move that red ink down a little in terms of putting bones back together from automobile accidents?

Mr. STARK. The converse of that would be to charge a higher premium to those persons who smoked. It is a little difficult.

Chairman JACOBS. How is there a way to know that somebody is wearing a seatbelt, for example?

Mr. STARK. I have a little problem telling the American public what to do. We are trying in California, for instance, to tell people—for what reason eludes me at this time—to vote no on the State lottery. They read about the guy who got $40 million in Chicago a week or so ago. And to me that seems to be political suicide. It is like motorcycle helmets. I think to arrest somebody for not wearing a helmet is wrong.

I think we should put a sign on every motorcycle that says, "A Fool If You Don't Wear The Helmet." But I don't think we can legislate that out.

Chairman JACOBS. I don't think you understand my proposal. The fact is not to tell them what to do but to tell them what we will do under certain circumstances.

Mr. STARK. General Motors does that now. They will give you a policy if you buy a new General Motors car. And if you are wearing a seatbelt and you are injured in an accident, they will give you up to $10,000.

Chairman JACOBS. If there is a facility and the seatbelt is secured, that is right.

I am not a reformed police officer—you say you are a reformed smoker. I served as a police officer, and I scraped too many people off windshields not to remember for all the days of my life the importance of restraints. People will put seatbelts on in airplanes where the chance of saving their lives is infinitesimally smaller than using it in the automobile.

I am toying with the idea of not telling people they have to put their seatbelts on but tell them what money the trust fund will pay if there is contributory negligence which caused or failed to mitigate the injury, for which the trust fund must pay out money.

Mr. Duncan.

Mr. DUNCAN. Mr. Stark, you indicated that the opposition to increasing the tax was from the tobacco industry alone.

Are you not aware of the fact that the National Governors Conference and all the Governors have been opposed to this because they want the tobacco tax left to the States?

Mr. STARK. The gentleman is quite correct. And I don't like to indicate any pejorative intent toward the industry. I will be surprised if any industry would not resist an increase in their own excise taxes, and that makes infinite good sense to me, I think, recognizing both the problem that the State Governors have—although I have a hunch that a concomitant savings to the States in their costs for Medicaid and Medicare might erode some of that opposition.

I was quite serious; I think that politically to work a compromise with our good colleagues they must, by the nature of their election, represent their constituents who have an interest in this, find a way to compromise. As the gentleman from Tennessee knows, he and I have worked over the years on compromises on other issues, and I think that the statistics will bear out that, given time—by that I mean perhaps in the frame of a year or two—every time we have increased taxes on cigarettes or on wine or beer or liquor, the sales come back. And it is that period of dislocation while people adjust to that next higher price that I think we have to protect.

I think we have to look with some concern on most tobacco farmers who are small farmers—very important—average cash income of about $3,000—and find a way to solve that problem. We must have 40 of our colleagues in the House who worry every 2 years about what we are going to do with these small farmers and we must take them into consideration.

I have a hunch that we can find a political solution in this same manner that would let them compromise with us and find a way that would be politically palatable to fund a large portion of our medical costs, I think, if we work at it seriously with the understanding we will never get it unless we work out that compromise. And perhaps the time has come.

We will be looking next year, in any event, for ways to save money in Government spending and slash or to raise revenues in ways that politically for either party will be acceptable.

I think, in all seriousness, this is one that I would rather consider in that light than as we so often consider these things at 3 or 4 a.m., in a conference committee, as we try to balance out an agreement to raise a certain amount of revenue. I think we would all do a better job of legislating if we could work at it from the beginning. And I would look forward—as we all anticipate the gentleman from Tennessee will be our ranking member next year—I look forward to working with him and the chairman to see if we can't find a way to accomplish that.

I think we see it coming. I think we could face it in a way that would do credit to our reputations as legislators.

The gentleman from Tennessee doesn't need as much help as I do, but I think it is important we face it. I hope the committee will place it on their agenda and that we can proceed with it.

Mr. DUNCAN. May I say there is no more understanding person on the committee to work with than you.

Mr. STARK. I thank the gentleman.

Mr. DUNCAN. Let me ask you a question: Are you aware of the report that was in the newspaper, I think about a week ago, where NIH raised some question about the effects of tobacco on cancer?

Mr. STARK. I am not aware of that article, Mr. Duncan. I am aware of some continuing controversy over exactly what harmful effects tobacco may have on the body.

I will say that unfortunately the problem we are discussing will not be solved by scientists. It is not going to be certain. It is going to be solved by people like myself who have to sense the mood of the public, which is our job. And, you know, if we could turn it over to the physicians and scientific research people and say you come up with a number, and get away with it, that might be a solution you and I could live with. But we can't do that.

I think that there is a majority of people who believe that there are harmful health effects, and I think that is what we are dealing with.

I certainly would agree with the gentleman that there is a great deal of controversy, and highly reputable scientists and physicians have differing views of what the effects of tobacco are. But I think that we are dealing with a universe where the preponderance of belief is on the side that they are harmful. Certainly, that is what my mother and father both told me as they smoked cigarettes and cigars.

Mr. DUNCAN. I am neither a producer nor consumer of tobacco products. Thank you, Mr. Chairman.

Chairman JACOBS. Thank you.

Our next witness is Congressman Don Bonker, State of Washington. He is a foreign affairs person with status in the world.

Thank you for your appearance. You dressed much better than when I last saw you.

STATEMENT OF HON. DON BONKER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Mr. BONKER. Thank you, Mr. Chairman.

Chairman JACOBS. Proceed at your own wish.

Mr. BONKER. Thank you for this opportunity this morning to schedule hearings on this important subject, one which Congress must address almost immediately.

Twenty years ago, I was a young staff assistant assigned to the Senate Committee on Aging at the time when we came up with the Medicare bill, and if I recall at that time the original draft really provided for 100 percent coverage. But in the process of negotiating with its adversaries, we were actually—we reduced the benefits to where at that time Medicare was to cover about 80 percent of all the related costs of providing health care to senior citizens—80 percent back in 1964.

Now, 20 years later, Medicare covers approximately 45 percent. And if recent action by this Congress is any indication, the percentage covered by Medicare will be going progressively down instead of up. Just in the recent actions of this body, we had in 1982, in that Tax Equity Act, $13 billion in so-called savings, which actually came out of the hide of Medicare. And then, of course, the DRG reimbursement program is being implemented to bring about more

savings. And then recently the Deficit Reduction Act carried another $14 billion or $13 billion in so-called savings by increasing premiums and putting a freeze on physician fees. So, if anything, we are probably going to see even more reductions in Medicare coverage.

What I would like to discuss with you briefly this morning, Mr. Chairman, is a new approach that deals not so much with the impending solvency question of the trust fund, but another aspect of Medicare that relates to medigap.

I think all of us, as Congressmen, when we are in our districts, encounter complaints and concerns among senior citizens that have to deal with the complex accounting that generally follows inpatient treatment; Medicare covers so much, and then coinsurance covers another part. And then the patient, once he sorts through all that, then is left with paying the difference.

Medigap is not a good program for supplementing basic health care under Medicare. I sit now on the Select Committee on Aging, and in the past few Congresses we have looked at the medigap insurance, and there are a lot of gaps in medigap. So what I have introduced by way of legislation—and it is pending before your committee—is H.R. 4487, which I believe will reduce health costs to Medicare beneficiaries and simplify the accounting procedures for paying your bills, and also conceivably could add money into the trust fund if we are looking for ingenious ways of enhancing financially the state of that trust fund.

Let me just explain very briefly what my legislation would do. It would actually provide an alternative to medigap or coinsurance simply by increasing the monthly premium and extending the benefits under both parts A and B. Right now, the medigap provides, as you know, additional coverage under part A beyond sometimes the hospital deductible to cover all copayments for hospital care above the 30 days, and all hospital days beyond the 60 lifetime days.

The idea is that we would provide that coverage under part A so that the beneficiary would not have to go out and find additional insurance to give them that coverage. If we were to do that, according to actuarial studies that we have we would need only increase the premium payment by a small amount—I think it is $3.75; $3.25 under part A.

We would then apply the same concept to part B. In other words, by increasing the premium we would be able to provide adequate coverage that is now supplied by coinsurance, and that would cost an additional $14.50 under part B. Thus, Mr. Chairman, by adding in premium costs approximately $17.75, we have done away with the need for extra health insurance.

Now, the cost estimates I have here, which are fairly conservative, is that presently beneficiaries are paying, I think, $13.70 in their premium payments; and the approximate figure for coinsurance is running about $30 a month. I know it ranges from probably $30 to something else, but on average Medicare recipients are now paying about $43.70 for their health insurance. With that, they have to sort through who pays what and go through a very complex accounting procedure.

Under the legislation I have introduced and which is before your committee, H.R. 4487, the recipient would pay the $13.70, as he or she now does, and then in addition for complete coverage under parts A and B would pay an additional $17.75. That comes to $31.45, about $12 a month less, cheaper, than what is now provided under the present system.

Nationwide, Medicare recipients are paying about $8 billion for coinsurance. My bill provides a savings of about $1 billion. Again, there are other benefits.

I might add that if we need to find additional revenue, we could probably increase that premium a little more and still the recipient would pay less and probably get more than what they are now getting under the present system.

Mr. Chairman, I am really pleased that you have invited me to testify today. And I would hope that you and the panel and your staffs would look at this legislation, since you are conducting hearings on reform of the Medicare system. I think the time is due now for us to confront this medigap insurance problem where there have been a lot of abuses and where we have utterly confused senior citizens who are trying to cope with their health care needs.

Thank you.

[The prepared statement follows:]

STATEMENT OF HON. DON BONKER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Good morning. I am very pleased to be appearing before the Committee this morning to discuss H.R. 4487, a bill I have authored to help Medicare beneficiaries cope with the high cost of health care.

The provisions of my bill expand Medicare by offering its beneficiaries two additional supplementary medical insurance options. The first option would allow older Americans to purchase more comprehensive benefit coverage under Parts A & B. The second option would permit beneficiaries to buy coverage for outpatient prescription drugs used in the treatment of chronic illness.

Premiums for these two new options would be calculated to reflect the actual cost of benefit coverage. Thus, enactment of H.R. 4487 would not add to the nation's deficit or the HI Trust Fund's financial problems. Because of the Medicare program's low administrative costs, the combined premium amount for the two options would be lower than the elderly pay for the more limited medigap coverage they now buy from private sector insurers. As a result, this legislation would reduce out-of-pocket health costs for seniors who choose to select one or both of the new options. Equally important, much of the confusion that pervades Medicare's current structure would be eliminated, both for elderly Americans and for providers serving older consumers.

Before discussing some of the major aspects of my bill in more detail, I would like to tell you why I consider its passage so essential.

Medicare was enacted in 1965 to alleviate the serious health care financing problems faced by the elderly. At that time the cost of basic health care was beyond the reach of many older Americans. On the average, seniors were paying 20 percent of their income for health care. Although often portrayed by many as comprehensive in purpose, medicare was designed to reflect the private insurance model. Consistent with this model, copayments and deductibles were made part of the structure.

Without question, Medicare has been of immense assistance to seniors. Yet as medicare approaches its 20 year anniversary we are confronted with a paradoxical problem which, while not new, has recently become more severe. Both Medicare expenditures and the financial burden faced by the elderly in paying for care are growing. Data published by the Senate Aging Committee confirms that the percentage share of income the elderly spend on health care has once again risen to 20 percent. In addition, Medicare's share of the total cost of health care to older persons has remained at about 45 percent over the least few years.

For all too many Medicare beneficiaries the cost of an acute but serious illness is becoming catastrophic. Let me provide some information I had my staff prepare with the technical experts who have been working with me on my bill.

(1) Someone with an 85 day hospital stay would be responsible for paying $2,581 in out-of-pocket expenses. Costsharing would total $8,366 for a 120 day stay.

(2) A beneficiary using 100 days of skilled nursing care would probably be responsible for about half the cost of that care, or about $3,500.

(3) While 80% of reasonable physician charges is covered by Medicare, over 11% of all aged Medicare beneficiaries will be responsible for an average of almost $1,700 for physician and related services not covered under SMI. Of this, almost $700 will be for charges on unassigned claims, most of which will not even be covered by medigap insurance.

(4) Approximatley 2% of the elderly, even assuming that all their Part B claims were covered and assigned, would be personally responsible for an average $2,000 this year for services billed under Part B.

Now, these examples certainly do not reflect situations faced by the average Medicare beneficiary. Nevertheless, the possibility of their occurrence is ever-present and remains a constant source of anxiety for those living on fixed incomes with limited assets.

Since Medicare's enactment, a piecemeal system of public and private protection has been developed to help pay for expenses not covered by the program. About two-thirds of the Medicare's beneficiaries are protected against potentially large medical expenses through the private insurance market. They purchase what is commonly known as "medigap" insurance. But, the cost of this protection is high and the extent of coverage varied.

Another 13 percent of the elderly are protected by Medicaid which acts as a supplement to Medicare. Neither of these forms of protection is adequate. And, compounding this dilemma, there is now considerable pressure to reduce Medicare benefits or increase costsharing both, as a means of shrinking the overall Federal deficit and solving the HI Trust Fund's financial crisis.

Any solution to this dilemma must achieve two apparently contradictory goals of reducing program costs and increasing protection for the elderly. In the past I have authored and actively supported legislation to expand Medicare's basic benefits package and reduce costsharing. I have done so because I firmly believe that this country has an obligation to assure that seniors are able to obtain the health care services they need. Unfortunately, the HI trust fund's problems make an real expansion of Medicare benefits on that scale impossible in the near future. Health care costs must be brought under control first throughout the health care delivery system.

The elderly must not be made to pay for what is, in some instances, our political inability to control the medical establishment. Until we can come to grips with this problem, we have a commitment to insure that Medicare beneficiaries get the best coverage they can for the money they have to spend. That is why I have introduced H.R. 4487 and plan to reintroduce it in the next Congress.

I would now like to turn to a discussion of H.R. 4487's specific provisions. First, each individual that chooses to enroll in the SMI, or part B program would be given the opportunity to voluntarily select additional insurance coverage for most costsharing requirements under part A and part B. This medigap coverage would include all but the first hospital deductible in a given year, all copayments for hospital care above the 60th day, and all hospital care beyond the 60th lifetime day. All complicated spell-of-illness requirements would be eliminated. In addition, the 20 percent part B coinsurance requirement would be covered up to the reasonable charge level allowed by medicare.

Enrollee premiums for this optional comprehensive insurance coverage would be calculated by Medicare actuaries to reflect the actual cost of coverage. No new payroll tax of Federal general revenues would be required. The primary advantages to the Medicare beneficiary would be the low cost of the premium, better coverage and less confusion about their benefits. If implemented immediately, the cost of the comprehensive coverage option would be about $18 more per month, which is considerably lower than medigap insurers charge for similar coverage. Older Americans now spend over $8 billion on medigap insurance. Selection of this option could save them $1 billion annually.

Second, each individual who chooses to enroll in the SMI program would be given a one-time opportunity to voluntarily select coverage of outpatient drugs used in the treatment of chronic illnesses. As with the first option, enrollee premiums would be calculated by medicare actuaries to reflect the actual cost of coverage. A restricted drug benefit formula would be developed by the Secretary of Health and Human

Services, as well as a predetermined payment rate and claims processing system in which druggists would be required to take assignment for the payment of covered drugs.

The most recent data, gathered in 1977 indicates that older Americans spent over $1.5 billion annually on prescriptions; $1.2 billion of that amount came out of their own pockets. Because a substantial proportion of drug expenditures are paid for by a small percentage of the elderly with chronic illnesses, the SMI drug option would afford important protection against the heavy costs of long-term disease. The premium would be about $8 per month.

My bill offers substantial advantages to both consumers and providers of health care. Clearly, the enactment of the legislation would save Medicare beneficiaries money. But, the proposal would also be easy to administer because Medicare already collects premiums and pays bills. Hospitals would no longer need to be bill collectors in their efforts to collect deductibles and copayments. Finally, physicians who take assignment would have all SMI benefits coordinated by medicare, thus eliminating some of their administrative costs and difficulties.

There will undoubtedly be criticisms levied against this bill on a number of fronts. Many will oppose it as they would any other expanded role for government in the health care field. Others will say that additional, low cost SMI protection would encourage adverse selection and greater utilization of service. I disagree with both of these possible criticisms. Adequate safeguards have been built in to discourage adverse selection and increased utilization. There is a 12-month waiting period for enrollees who initially reject, but subsequently choose, more comprehensive coverage of benefits under parts A and B. And, beneficiaries initially rejecting drug coverage would not be able to enroll at a later date.

I want to reemphasize that this bill is not intended as a solution to the health care financing problems facing our nation's elderly. The cost-sharing burden placed on senior citizens under the present Medicare program is intolerable and must be removed. It is because of my strong commitment to removal of this burden that my bill directs the HHS Secretary to report to Congress on alternatives for reducing cost-sharing elements for the Medicare program. Hopefully, by 1988, when the proof would be issued, legislative solutions to the HI trust fund crisis and health care costs in general will be in place.

My legislation is designed to ease the financial problems faced by senior citizens in meeting their basic daily needs. It is one way that we can act to guarantee that the gains we have made will not be eroded. I urge your careful consideration of this measure.

Chairman JACOBS. Thank you.

Congressman Duncan.

Mr. DUNCAN. I have no questions other than to thank our colleague for a very excellent presentation. Thank you.

Mr. BONKER. Thank you, Mr. Duncan.

Chairman JACOBS. It is different and therefore I think it enriches the record. I appreciate your contribution; and this committee does, too. We will take a good look at it.

Mr. BONKER. Thank you.

Chairman JACOBS. Our next witness, from the Congressional Budget Office, is Dr. Eric Hanushek.

Have I properly pronounced your name?

STATEMENT OF ERIC A. HANUSHEK, DEPUTY DIRECTOR, CONGRESSIONAL BUDGET OFFICE, ACCOMPANIED BY CHARLES SEAGRAVE AND HINDA RIPPS CHAIKIND

Mr. HANUSHEK. Mr. Chairman, I answer to a variety of pronunciations. But I usually use "Hanushek."

Chairman JACOBS. Thank you very much. Please proceed.

Mr. HANUSHEK. Before I begin, I would like to introduce Chuck Seagrave and Hinda Ripps Chaikind from the Congressional Budget Office who have joined me today.

Mr. Chairman, I am pleased to appear before the committee today to discuss the hospital insurance trust fund. The fund faces two distinct but related financial pressures. First, hospital insurance expenditures represent a rising proportion of total Federal spending and contribute to Federal budget deficits, which the Congressional Budget Office projects will rise dramatically over the next 5 years. Second, the hospital insurance trust fund itself faces potential financial insolvency in the coming decade.

My testimony will focus on CBO's completed August baseline projections of outlays, income, and balances in Medicare's hospital insurance trust fund from 1985 to 1995, as well as on various uncertainties in making projections of program growth and the sensitivity of or to alternative assumptions.

At the outset, I should note that projecting trust fund balances is very difficult to do with any certainty. The outlay projections are particularly difficult because a new hospital reimbursement system has recently been established, and its effects are not yet fully understood. Nevertheless, since outlays are projected to grow considerably faster than revenues, we anticipate that the balances in the hospital insurance trust fund will fall to zero sometime in the mid-1990's.

CBO BASELINE ESTIMATES

The hospital insurance [HI] portion of Medicare covers hospital, home health, and skilled nursing care for 30 million aged and disabled persons. CBO estimates that the HI trust fund will spend $48 billion in fiscal year 1985, while receiving $52 billion in income. This $52 billion includes $47 billion in payroll taxes, with the remaining income being primarily interest.

Because revenues are estimated to grow more rapidly in the beginning of the projection period than at the end, the trust fund balance is expected to increase through 1989 and then begin to decline. Under CBO's baseline assumptions, outlays are projected to be $146 billion by 1995—some 36 percent above revenues in that year. These baseline projections are displayed in table 1.

OUTLAYS

The projected annual growth in spending of 11.8 percent incorporates projected increases in basic hospital costs, enrollment, and utilization, as well as other factors.

The basic cost of providing hospital care is estimated from the cost of a market basket of goods and services purchased by hospitals. Labor costs, which account for almost two-thirds of the total market basket, are assumed to grow at an average rate of more than 6 percent per year. The costs of capital goods and supplies—the remaining items in the market basket—are assumed to grow at the same rate as consumer prices in general. Under CBO's baseline economic assumptions, the total market basket for hospital costs is projected to increase by about 6 percent annually.

Beginning in October 1983, hospital reimbursement under Medicare underwent a major change from a cost-based system to a system of prospective payments based on diagnosis related groups [DRG's]. This system was designed for gradual implementation and

is expected to be fully in place by 1986. Under the new system, hospitals are reimbursed according to a fixed payment for each of 468 different diagnoses.

Outlays will be directly related to these DRG rates. Under existing law, the DRG rates are set to be budget-neutral through 1985, meaning that they should have no cost or savings impact on Medicare hospital reimbursement relative to law prior to enactment of the Social Security Amendment of 1983.

CBO's baseline estimates for 1985 are based on preliminary regulations issued by the Secretary of Health and Human Services on July 3, 1984, which specify a budget-neutral rate of increase in 1985. The final regulations were released by the Secretary of Health and Human Services on August 31, 1984. These regulations will result in slightly higher projected HI outlays than estimated in the baseline, but will have only a marginal impact on the trust fund's financial problem.

In 1986, the increase in the DRG rate cannot exceed the market basket increase plus .25 percent, as specified by the Deficit Reduction Act. After 1986, the Secretary will determine increases in the DRG rates in consultation with the Prospective Payment Commission.

CBO's projected HI increases beyond 1986 assume a growth rate equal to the market basket rate plus 1 percent, following the convention used by the HI actuaries. The additional 1 percent is designated to allow for improvements in medical technology. These estimated increases in the DRG rate can be thought of as the increases in the unit costs of covered hospital activities.

HI outlays will grow more rapidly than these unit costs, however. Additional annual increases in HI outlay growth stem from increases in program enrollment and in hospital admission rates, which are projected to be 2 percent and 1 percent a year, respectively.

Finally, CBO's projections include another cost increase of 1.5 percent a year to allow for other growth in Medicare hospital reimbursement not specifically limited by the Secretary. This growth, for example, could be the result of changes in hospital admitting practices that change the mix of procedures performed, thereby increasing the average cost per admission. In response to the implementation of the DRG system, this residual growth is projected to be slightly lower than in the past. Combined, these yield an average total outlay growth of 11.8 percent a year.

INCOME

Revenues flow into the trust fund mainly through payroll taxes, although some income is derived from interest earned on balances and from general revenue transfers. Payroll tax receipts depend on wages and salaries and on employment. Increases in wages and salaries determine the per-person increases in revenues to the trust fund; the level of employment determines the pool of individuals to be taxed.

The 7.5 percent average annual growth in revenues over the entire period is best explained in two time frames—pre- and post-1989. Between 1985 and 1989, a very special set of circumstances

will increase income to the HI trust fund; after 1989, income growth will average only 6 percent per year.

Two factors dominate the early period: first, the old age and survivors insurance trust fund [OASI] is expected to repay a loan of $12.4 billion to the HI trust fund; second, the HI payroll tax rate is scheduled to increase from 1.30 to 1.35 percent in 1985 and to 1.45 percent in 1986—an overall increase of 12 percent. No tax increases are scheduled after 1986.

Thus, while spending is projected to continue to increase by over 11 percent a year, income growth is expected to keep pace only through 1989. After 1989, when the loan to the OASI trust fund is fully repaid and all scheduled HI payroll tax increases are in place, the trust fund balance is projected to decline steadily.

UNCERTAINTIES IN PROTECTING PROGRAM GROWTH

Estimates of the financial status of the trust fund are very sensitive to the projected growth rate of outlays. Unfortunately, recent reimbursement patterns to hospitals have heightened our uncertainty about such projections.

Since August 1983, spending for HI has been much lower than previously predicted. Based on actual HI outlay data for the first 10 months of fiscal year 1984, CBO now estimates that 1984 outlays will be only 10 percent greater than those in 1983. This is considerably below historical growth rates. Part of this change simply reflects the low overall inflation rate for wages and other inputs during 1984, but part undoubtedly reflects the introduction of the new DRG reimbursement system.

In making projections, temporary adjustment factors must be separated out from long-term improvements in the hospital cost picture. Because the prospective payment system is new, hospitals can be expected to go through some temporary adjustments that involve learning the mechanics of the system, understanding where the rate structure is most binding, and so forth. These factors, which might initially hold down HI outlays, should lessen over time and would therefore not affect the long-run performance of the system.

On the other hand, many recent changes in the hospital industry might have more enduring effects on cost growth. For example, in partial response to consumer, business, and Government concerns over rising health care costs, many new health organizations are being formed. Health maintenance organizations [HMO's], preferred provider organizations [PPO's], and State and local government cost control plans are growing in size and importance. These groups could affect both hospital admission rates and hospital costs.

Simultaneously, during the last year there has been an unexpected dip in the rate of increase of hospital admissions for those age 65 and older. This decline in the rate of growth of admissions is the opposite of what many observers thought would result from DRG pricing—namely, that hospitals would increase admissions to compensate for lower per-admission reimbursements. All of these factors make forecasting the growth in health care costs over the next decade a very uncertain task.

I want to emphasize that while the exact path of HI fund balances is highly uncertain, severe financial problems are ultimately very likely even with more optimistic assumptions about lower outlay growth. Table 2 shows CBO baseline projections modified by a 1-percentage point increase or decrease in the rate of change for Medicare hospital reimbursement. For example, if the growth rate in Medicare hospital reimbursement is 1 percentage point lower than assumed in the baseline, the trust fund balance will be $0.4 billion higher for the first year. This amount accumulates over time, so that by 1989 the balance would be $9 billion higher than the baseline estimates. By 1995, the difference would total $77 billion.

While the financial status of the trust fund under this lower growth path of outlays is obviously improved, the trust fund would ultimately be depleted because growth in outlays still exceeds growth in trust fund income. Conversely, if the increase in hospital reimbursement were 1 percentage point higher than assumed in the baseline, the trust fund would be depleted in 1992, and by 1995 the deficit would grow to $138 billion, some $82 billion more than the baseline estimate.

Several specific examples of that uncertainty in the forecasts can be cited—namely, that arising from DRG rate increases, that arising from how the system and other factors affect hospital use, and, to a lesser extent, that arising from the underlying macroeconomic forecasts.

The DRG rate increases for 1985 are now known; those for 1986 and beyond remain uncertain. The Deficit Reduction Act caps the 1986 growth on the DRG rate at that of the market basket plus 0.25 percent, and the CBO baseline assumes that the actual increase will equal this cap. After 1986, no limits are specified by law, and the Secretary of Health and Human Services must specify the annual changes. The Secretary thus has discretionary power over future increases, although payments will almost certainly reflect movements in aggregate hospital costs. CBO baseline estimates, as described above, assume that the DRG rate increases at 1 percent above the increases in the cost of the market basket.

Perhaps the greatest uncertainty, however, revolves around how hospitals react to the DRG system and other pressures in terms of hospital utilization, admitting practices, and pattern of admissions. For example, hospitals could switch certain diagnoses from outpatient to inpatient care, or vice versa. Hospitals could also continue a movement toward a more complex caseload mix, a trend that has already been observed. With the system not yet fully in place, however, it is still too early to determine the effect of DRG's on hospital behavior.

Our projections of trust fund finances depend, to a large extent, on projections of wages and prices for the economy as a whole. Because inflation and growth affect both outlays and revenues, however, our projections of the financial status of the trust fund are not very sensitive to changes in our macroeconomic assumptions. Barring some unexpected change in real wage growth, the trust fund's long-run financial stability will depend most on hospital behavior and DRG rate policy. The exact timing of the depletion of

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the fund, however, could be sensitive to possible economic fluctuations.

In conclusion, the alternatives I have discussed demonstrate that the projections of HI spending are sensitive to many factors. As the DRG system is fully implemented, some of this uncertainty should dissipate. Nevertheless, growth in spending is projected to outpace the growth in revenues, so that the trust fund is likely to be either in critical condition or depleted in the 1990's.

The financial status of the HI trust fund does not suggest an urgent need to take action immediately. Two things, however, should be pointed out. First, since some action will ultimately be required, beginning adjustments early generally allows for the most options in dealing with the situation and helps mitigate any disruptions caused by large and sudden policy changes. Second, any action taken to improve the financial status of the trust fund has the added advantage of improving the overall deficit in the unified budget.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF ERIC A. HANUSHEK, DEPUTY DIRECTOR, CONGRESSIONAL BUDGET OFFICE

Mr. Chairman, I am pleased to appear before the Committee today to discuss the Hospital Insurance Trust Fund. The fund faces two distinct but related financial pressures. First, hospital insurance expenditures represent a rising proportion of total federal spending and contribute to federal budget deficits, which the Congressional Budget Office (CBO) projects will rise dramatically over the next five years. Second, the Hospital Insurance Trust Fund itself faces potential financial insolvency in the coming decade.

Since you asked me to address specifically the trust fund issue, my testimony today will focus on CBO's recent projections of outlays, income, and balances in the Hospital Insurance Trust Fund. It will concentrate on the following:

Our recently completed August baseline projections of Medicare's Hospital Insurance Trust Fund from 1985 to 1995; and

Various uncertainties in making projections of program growth and the sensitivity to alternative assumptions.

Projecting trust fund balances is very difficult to do with any certainty. The outlay projections are particularly difficult because a new hospital reimbursement system has recently been established, and its effects are not yet fully understood. Nevertheless, since outlays are projected to grow considerably faster than revenues, we anticipate that the balances in the Hospital Insurance Trust Fund will fall to zero sometime in the mid-1990s.

CBO BASELINE ESTIMATES

The Hospital Insurance (HI) portion of Medicare covers hospital, home health, and skilled nursing care for 30 million aged and disabled persons. CBO estimates that the HI trust fund will spend $48 billion in fiscal year 1985, while receiving $52 billion in income. This $52 billion includes $47 billion in payroll taxes, with the remaining income being primarily interest. Because revenues are estimated to grow more rapidly in the beginning of the projection period than at the end, the trust fund balance is expected to increase through 1989 and then begin to decline. Under CBO's baseline assumptions, outlays are projected to be $146 billion by 1995—some 36 percent above revenues in that year. These baseline projections are displayed in Table 1.

Outlays

The projected annual growth in spending of 11.8 percent incorporates projected increases in basic hospital costs, enrollment, and utilization, as well as other factors.

TABLE 1.—BASELINE BUDGET PROJECTIONS OF HOSPITAL INSURANCE TRUST FUND OUTLAYS, INCOME, AND BALANCES

[By fiscal year, in billions of dollars]

Years	Total outlays	Income	Year-end balance
1985	48	52	20
1986	53	61	29
1987	59	73	43
1988	66	72	49
1989	74	75	51
1990	82	79	48
1991	92	85	41
1992	103	91	28
1993	116	97	9
1994	130	102	−18
1995	146	107	−56

Source: Congressional Budget Office, August 1984 estimates.

The basic cost of providing hospital care is estimated from the cost of a market basket of goods and services purchased by hospitals. Labor costs, which account for almost two-thirds of the total market basket, are assumed to grow at an average rate of more than 6 percent per year. The costs of capital goods and supplies—the remaining items in the market basket—are assumed to grow at the same rate as consumer prices in general. Under CBO's baseline economic assumptions, the total market basket for hospital costs is projected to increase by about 6 percent annually.

Beginning in October of 1983, hospital reimbursement under Medicare underwent a major change from a cost-based system to a system of prospective payments based on Diagnosis Related Groups (DRGs). This system was designed for gradual implementation and is expected to be full in place by 1986. Under the new system, hospitals are reimbursed according to a fixed payment of each of 468 different diagnosis.

Outlays will be directly related to these DRG rates. Under existing law, the DRG rates are set to be budget-neutral through 1985, meaning that they should have no cost or savings impact on Medicare hospital reimbursement relative to law prior to enactment of the Social Security Amendment of 1983. CBO's baseline estimates for 1985 are based on preliminary regulations issued by the Secretary of Health and Human Services on July 3, 1984, which specify a budget-neutral rate of increase in 1985.[1] In 1986, the increase in the DRG rate cannot exceed the market basket increase plus 0.25 percent, as specified by the Deficit Reduction Act. After 1965, the Secretary will determine increases in the DRG rates in consultation with the Prospective Payment Commission. CBO's projected HI increases beyond 1986 assume a growth rate equal to the market basket rate plus 1 percent is designed to allow for improvements in medical technology. These estimated increases in the DRG rate can be thought of as the increases in the unit costs of covered hospital activities.

HI outlays will grow more rapidly than these unit costs, however. Additional annual increases in HI outlay growth stem from increases in program enrollment and in hospital admission rates. These are projected to be 2 percent and 1 percent per year, respectively. Finally, CBO's projections include another cost increase of 1.5 percent per year to allow for other growth in Medicare hospital reimbursement not specifically limited by the Secretary. This growth, for example, could be the result of changes in hospital admitting practices that change the mix of procedures performed thereby increasing the average cost per admission. In response to the implementation of the DRG system, this residual growth is projected to be slightly lower than in past experience. Combined, these yield an average total outlay growth of 11.8 percent per year.

Revenues

On the income side, revenues flow into the trust fund mainly through payroll taxes, although some income is derived from interest earned on balances and from

[1] The final regulations were released by the Secretary of Health and Human Services on Aug. 31, 1984. These regulations will result in slightly higher projected HI outlays than estimated in baseline, but will have only a marginal impact on the trust fund's financial problem.

general revenue transfers. Payroll tax receipts depend on wages and salaries and on employment. Increases in wages and salaries determine the per-person increases in revenues to the trust fund, while the level of employment determines the pool of individuals to be taxed.

The 7.5 percent average annual growth in revenues over the entire period is best explained in two time frames—pre- and post-1989. Between 1985 and 1989, a very special set of circumstances will increase income to the HI trust fund, and after 1989 income growth will average only 6 percent. Two factors dominate the early period: first, the Old Age and Survivors Insurance (OASI) Trust Fund is expected to repay a loan of $12.4 billion to the HI trust fund; second, the HI payroll tax rate is scheduled to increase from 1.3 percent to 1.35 percent in 1985 and to 1.45 percent in 1986—an overall increase of 12 percent. No tax increases are scheduled after 1986.

Thus, while spending is projected to continue to increase by over 11 percent a year, income growth is expected to keep pace only through 1989. After 1989, when the loan to the OASI trust fund is fully repaid and all scheduled HI payroll tax increases are in place, the trust fund balance is projected to decline steadily.

UNCERTAINTIES IN PROJECTING PROGRAM GROWTH

Estimates of the financial status of the trust fund are very sensitive to the projected growth rate of outlays. Unfortunately, recent reimbursement patterns to hospitals have heightened our uncertainty about such projections.

Since August 1983, spending for HI has been much lower than previously predicted. Based on actual HI outlay data for the first 10 months of fiscal year 1984, CBO now estimates that 1984 outlays will be only 10 percent greater than those in 1983. This is considerably below historical growth rates. Part of this change simply reflects the low overall inflation rate for wages and other inputs during 1984, but part undoubtedly reflects the introduction of the new DRG reimbursement system.

For projection purposes, the problem is to separate out temporary adjustment factors from long-term improvements in the hospital cost picture. Because the prospective payment system is new, hospitals can be expected to go through some temporary adjustments that involve learning the mechanics of the system, understanding where the rate structure is most binding, and so forth. These factors, which might initially hold down HI outlays, should lessen over time and would therefore not affect the long-run performance of the system.

On the other hand, many changes have been occuring in the hospital industry that might have more enduring effects on cost growth. For example, in partial response to consumer, business, and government concerns over rising health care costs, many new health organizations are being formed. Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and state and local government cost control plans are growing in size and importance. These groups could affect both hospital admissions rates and hospital costs. Simultaneously, during the last year there has been an unexpected dip in the rate of increase of hospital admissions for those age 65 and older. This decline in the rate of growth of admissions is the opposite of what many observers thought would result from DRG pricing—namely, that hospitals would increase admissions to compensate for lower per-admission reimbursements. All of these factors make forecasting the growth in healthcare costs over the next decade a very uncertain task.

While the exact path of HI fund balances is highly uncertain, severe financial problems are ultimately very likely even with more optimistic assumptions about lower outlay growth. Table 2 shows CBO baseline projections modified by a one percentage-point increase or decrease in the rate of change for Medicare hospital reimbursement. For example, if the growth rate in Medicare hospital reimbursement is one percentage point lower than assumed in the baseline, the trust fund balance will be $0.4 billion higher for the first year. The amount accumulates over time, so that by 1989 the balance would be $9 billion higher than the baseline estimates. By 1995, the difference would total $77 billion. While the financial status of the trust fund under this lower growth path of outlays is obviously improved, the trust fund would ultimately be depleted because growth in outlays still exceeds growth in trust fund income. Conversely, if the increase in hospital reimbursement were one percentage point higher than assumed in the baseline, the trust fund would be depleted in 1992 and by 1995 the deficit would grow to $138 billion, $82 billion more than the baseline estimate.

Several examples of uncertainty in the forecasts can be cited—namely, that arising from DRG rate increases, that arising from how the system and other factors affect hospital use, and, to a lesser extent, that arising from the underlying macroeconomic forecasts.

DRG rate increases

While rate increases for 1985 are now known, those for 1986 and beyond remain uncertain. The Deficit Reduction Act caps the 1986 growth on the DRG rate at that of the market basket plus 0.25 percent, and the CBO baseline assumes that the actual increase will equal this cap. After 1986, no limits are specified by law, and the Secretary of Health and Human Services must specify the annual changes. The Secretary thus has discretionary power over future increases, although payments will almost certainly reflect movements in aggregate hospital costs. The baseline estimates, as described above, assume that the DRG rate increase at 1 percent above the increases in the cost of the market basket.

TABLE 2.—PROJECTIONS OF HOSPITAL INSURANCE TRUST FUND OUTLAYS, INCOME, AND BALANCES UNDER ALTERNATIVE RATES OF INCREASES IN HOSPITAL COSTS

[By fiscal year, in billions of dollars]

	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Baseline path:											
Total outlays	48	53	59	66	74	82	92	103	116	130	146
Income	52	61	73	72	75	79	85	91	97	102	107
Year-end balance	20	29	43	49	51	48	41	28	9	−18	−56
Baseline path—assuming 1 percent less increase:											
Total outlays	48	52	57	64	70	78	87	97	107	119	132
Income	52	61	73	73	75	81	87	93	100	107	113
Year-end balance	21	30	46	55	60	62	63	59	52	40	21
Baseline path—assuming 1 percent more increase:											
Total outlays	49	54	60	68	77	87	98	111	125	141	160
Income	52	61	73	72	74	78	84	88	93	98	101
Year-end balance	20	27	40	44	41	33	19	−4	−35	−79	−138

Source: Congressional Budget Office, August 1984 estimates.

Effect of DRGs and other factors on hospital use

Perhaps the greatest uncertainty, however, revolves around how hospitals react to the DRG system and other pressures in terms of hospital utilization, admitting practices, and pattern of admissions. For example, hospitals could switch certain diagnoses from out-patient to in-patient care, or vice versa. Hospitals could also continue a movement toward a more complex caseload mix, a trend that has already been observed. With the system not yet fully in place, however, it is still too early to determine the effect of DRGs on hospital behavior.

Economic assumptions

Our projections of trust fund finances depend to a large extent on projections of wages and prices for the economy as a whole. Because inflation and growth affect both outlays and revenues, however, our projections of the financial status of the trust fund are not very sensitive to changes in our macroeconomic assumptions. Barring some unexpected change in real wage growth, the trust fund's long-run financial stability will depend most on hospital behavior and DRG rate policy. The exact timing of the depletion of the fund, however, could be sensitive to possible economic fluctuations.

CONCLUSION

The alternatives I have discussed demonstrate that the projections of HI spending are sensitive to many factors. As the DRG system is fully implemented, some of this uncertainty should dissipate. Nevertheless, growth in spending is projected to outpace the growth in revenues so that the trust fund is likely to be either in critical condition or depleted in the 1990s.

The financial status of the HI trust fund does not suggest an urgent need to take action immediately. Two things, however, should be pointed out. First, since action will ultimately be required, beginning adjustments early generally allows for the most options in dealing with the situation and helps mitigate any disruptions caused by large and sudden policy changes. Second, any action taken to improve the

financial status of the trust fund has the added advantage of improving the overall deficit in the unified budget.

Chairman JACOBS. Mr. Duncan.

Mr. DUNCAN. I have no questions, Mr. Chairman. Thank you.

Chairman JACOBS. Doctor, your contribution is, as your title implies, scholarly. And we are grateful to have it as a part of the record.

The committee, one way or another, is going to have work on this; it will have the work cut out for it over the next several years. And the work of your office will be a substantial contribution to try to work this through and figure out a solution to it. So we are in your debt. Thank you.

The committee will recess for such time as it may consume to go over and vote.

[Recess.]

Chairman JACOBS. Our next witness, from the American Federation of Labor and Congress of Industrial Organizations, is Ray Denison, director, department of legislation.

Mr. Denison, please come forward.

Mr. DENISON. Thank you, Mr. Chairman.

Chairman JACOBS. Come forward and be recognized, if you would.

Mr. DENISON. Good morning.

Chairman JACOBS. Mr. Denison, welcome, as usual. Please proceed.

Mr. DENISON. Thank you, Mr. Chairman.

Chairman JACOBS. You can throw in your statement, if you wish.

STATEMENT OF RAY DENISON, DIRECTOR, DEPARTMENT OF LEGISLATION, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS, ACCOMPANIED BY KAREN IGNAGNI, SOCIAL SECURITY DEPARTMENT, AFL-CIO

Mr. DENISON. Thank you.

The AFL-CIO would like to commend you, Mr. Chairman, for convening this hearing to receive comments on proposals put forth to solve the Medicare crisis and reduce the rate of increase in health care costs. We hope that this will be the first of a series of hearings by your subcommittee to discuss this important issue.

Our testimony today will focus on the report issued last March by the Social Security Advisory Council, and on H.R. 4870, the Medicare Solvency and Health Care Reform Act of 1984 sponsored by Congressman Richard Gephardt and by Senator Edward M. Kennedy.

Going first to the work of the Advisory Council, it was with great regret that organized labor was forced to oppose the recommendations put forth by the majority of the members of the Social Security Advisory Council. The two labor representatives who served on the council provided, as part of the Council's final report, a detailed statement of their dissenting views.

The AFL-CIO fully endorses that minority report. Essentially, we believe that the proposals put forth by the majority of Council members would hold harmless from accountability the primary decisionmakers in the health care system; namely, doctors and hospitals. Instead, it would place the financial burden of corrective

action on those who are the least responsible for rising costs and the least able to withstand increases in out-of-pocket payments—in other words, the Nation's elderly and disabled Medicare beneficiaries. Second, we believe that the majority's recommendations, even if fully implemented, would not prevent the predicted bankruptcy of the Medicare trust fund.

We in the AFL-CIO rejected the Council's recommendation for the following reasons: One, we did not support the view of the majority of the Council that general revenues not be used to fund the Medicare Program. It is our belief that as a minimum we will probably have to turn to general revenues as a stop gap until a solution is put into place. And that solution will come only when a comprehensive cost containment program to control rising health care costs is enacted.

Organized labor supports H.R. 4870, which will keep the Medicare trust fund solvent by limiting total health care spending. However, if this legislation is not passed in time to save Medicare, Congress should not foreclose the opportunity to use general revenues to preserve the program and protect its beneficiaries.

Two, we opposed placing limits on tax-free employer contributions to health insurance to fund the deficit in the Medicare Program. Proponents of this plan, including the administration, have claimed that the employee health tax proposal is designed to make workers more cost-conscious. In reality, it would result in drastic reductions in coverage for preventive care, outpatient diagnostic services, and other benefits which save money. It would leave a core of coverage for hospital and surgical benefits, which have been the chief source of health-cost inflation and costly overutilization, over which patients have little control.

Three, we opposed increasing taxes on alcohol and tobacco to raise revenue for the Medicare trust fund. These are excise taxes, the most regressive of all taxes, which would disproportionately impact the low income population and unfairly single out particular industries. As such, we have always opposed reliance on this method of revenue raising.

The earmarking of revenues to particular programs, with few exceptions, is poor tax policy. If tax revenues are to be used, let them come from the general revenues and not be subject to the social habits of our citizens. The negative economic and social effects of such a decision were not given sufficient consideration by the Council.

Four, we rejected the idea of increasing the Medicare part B deductible. We also opposed levying a surcharge on beneficiaries to help finance the deficit in the part A trust fund. Both proposals would shift to the elderly and disabled a larger share of the burden of rising Medicare costs, without doing anything to change the behavior of the true decisionmakers in the health care system.

Five, we also opposed raising the age of eligibility for Medicare from 65 to 67, beginning in 1985. The majority's proposal is inconsistent with the recently enacted Social Security amendments, which gradually begin raising the age of eligibility for Social Security benefits after the year 2000. In addition, we believe that there is little evidence to judge the impact of such an immediate change in eligibility. Only a relatively few individuals over age 65 will be

employed in jobs with good health insurance coverage. The rest will be unable to afford to purchase protection on their own, thus leaving millions of Americans to neglect their ills or be forced to seek care outside the system.

To summarize, we believe the recommendations of the Social Security Advisory Council's majority, if implemented, would shift to beneficiaries the financial risk of rising program expenditures. Instead, what is urgently needed is congressional enactment of an across-the-board cost containment program to control the rate of growth in private as well as public expenditures. Such a program would close the loopholes in the Medicare reimbursement system and save the program from bankruptcy.

As an alternative, the AFL–CIO urges consideration of H.R. 4870, the Medicare Solvency and Health Care Reform Act of 1984. This legislation, sponsored by Congressman Richard Gephardt and Senator Edward Kennedy, would control the annual rate of increase in health care costs by limiting reimbursement to providers from all payors, public and private. The legislation provides incentives to encourage States to establish their own cost containment plans within Federal guidelines. In our view, one of the prime advantages of this legislation is the flexibility given to States to design cost containment programs which deal with their individual problems and concerns.

We are very encouraged that the actuaries who have prepared cost estimates on the Kennedy-Gephardt bill have estimated that, if the legislation is passed in fiscal year 1985 and assuming no increase in payroll taxes, there will be a surplus in the Medicare trust fund until 2005, as compared to the projected cumulative deficit of over $150 billion by 1995.

In addition to the passage of cost containment legislation, we would also like to recommend that Congress consider improving the efficiency and quality of care associated with the Medicare Program by adopting some of the changes which have been implemented by labor and management in collective bargaining to reduce rising health care costs without reducing benefits. These initiatives include preventative health measures, ambulatory surgery, mandatory second surgical opinions, and alternative delivery systems, especially group practice HMO's. We have found that such cost containment initiatives can reduce health insurance premiums by 30 percent and play a major role in restraining the rate of increase in health care costs without reducing benefits. For example, the AFL–CIO Department Store Workers' Union in New York City found that once they instituted a mandatory second surgical opinion program, approximately 28 percent of initial recommendations for surgery were not confirmed by second opinions. It is unclear exactly how much these initiatives could reduce Medicare expenditures, but based on the experience in the private sector, we are confident these programs could reduce the rate of increase and significantly improve quality of care.

We believe the Kennedy-Gephardt bill offers a practical and equitable approach for improving the efficiency of the Medicare Program and substantially reducing program expenditures without harming beneficiaries. It provides strong financial incentives for the providers and suppliers of health care services to reduce unnec-

essary costs without increasing the already heavy financial burden on elderly and disabled Medicare beneficiaries, many of whom have been the chief victims of health care inflation.

We urge that H.R. 4870 be given full consideration by the Congress. The AFL-CIO is available to offer whatever assistance we can to help bring about an effective legislative remedy to ensure a healthy and viable Medicare Program.

Thank you.

Chairman JACOBS. Mr. Denison, what is the opinion of the AFL-CIO about the progress of the DRG's now? Does the organization have an attitude about that?

Mr. DENISON. Have we at this time had enough time to study their implementation and their effectiveness?

Chairman JACOBS. How are we doing?

Mr. DENISON. How are we doing?

Karen, do you want to respond to that?

This is Karen Ignagni of our Social Security department.

Ms. IGNAGNI. We believe on balance it is too early to really judge the impact of the DRG's. As you know, they were passed just fairly recently, last October, and the system is just really gearing up. However, we do have some concerns that hospital administrators are using the new DRG or PPS system as an excuse for not paying workers what they have negotiated or not adequately compensating them in future negotiations.

So, even though the DRG system is very new and only 25 percent of the hospital's payment is based on the PPS, we know from hospital administrators around the country that they are using this as an excuse to clamp down on the workers. We are quite concerned about that.

They do say, of course, that hospital labor costs amount to 50 percent of the overall hospital costs. But that does not include disaggregating supervisory and nonsupervisory personnel. When you take out the supervisory personnel who often are paid in excess of $50,000, $60,000 and $70,000, as compared to the $12,000 average rate that our workers are being paid, you get down to something like 25 to 30 percent. And we do not believe that the average waged workers, low waged workers, are driving the cost escalation spiral. But we have heard a number of observations to that effect from hospital administrators.

Chairman JACOBS. So you would rather see the hospitals use the DRG's as an excuse to trim down the high salaries; is that right?

Ms. IGNAGNI. That is right; precisely.

Chairman JACOBS. As long as it is to be used for something, it might as well be used for that.

We thank you for your contribution to the record. It is useful, as usual.

Mr. DENISON. Thank you, Mr. Chairman.

Chairman JACOBS. Our next witnesses are a panel: National Committee to Preserve Social Security and Medicare, Hon. James Roosevelt, chairman; American Association of Retired Persons, James Hacking, assistant legislative counsel; National Council of Senior Citizens, William R. Hutton, executive director; and Health Security Action Council, SOS Coalition to Protect Social Security,

and National Education Association, Melvin A. Glasser, director, Health Security Action Council.

Members of the panel, I have been informed that Mr. Roosevelt has a meeting which is at hand, for which he may be late, and I wonder if the panel would indulge us to allow Mr. Roosevelt to proceed first.

As I understand, Mr. Roosevelt, it may be necessary for you to leave before this panel completes its testimony.

Does anybody—could anybody—object to that?

Mr. Roosevelt, you are welcome to proceed. I welcome you as a former colleague, I should say, for the record.

STATEMENT OF JAMES ROOSEVELT, CHAIRMAN, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Mr. ROOSEVELT. I am pleased for this opportunity to come in and renew my friendship with you.

Chairman JACOBS. I think we served in one Congress together, at least.

Mr. ROOSEVELT. Right.

Mr. Chairman, as you have said, my name is James Roosevelt, chairman of the National Committee to Preserve Social Security and Medicare. The National Committee is a nationwide, nonprofit, tax-exempt organization founded in the District of Columbia late in 1982. Its membership today now totals approximately 624,000 people, many of whom are Social Security and Medicare beneficiaries.

The purpose of the National Committee is solely to protect the Social Security and Medicare Programs and to preserve the social insurance principles upon which these programs were founded.

Mr. Chairman, the very words "Medicare financing crisis" produce a fear in the hearts of elderly and disabled Americans who depend on Medicare insurance to cover a substantial portion of their hospital and doctor bills. Even now, Medicare reimburses only about 45 percent of total health care costs. Some people fear that an ill-considered rescue plan would cut Medicare benefits and require beneficiaries to pay even more out of pocket. Such a solution, of course, would destroy Medicare rather than rescue it.

Now, already on a reduced income, beneficiaries are expected to pay part B premiums that are going up at a faster rate than inflation, in 1985 and 1986. Health care cost inflation has increased the deductible for hospital care and the amount of copayment for physician care at a rate greater than normal inflation. Doctors accept assignment in only about half the cases, and the amount they are charging above Medicare approved fees is growing.

The Social Security financing crisis should be a lesson to us, Mr. Chairman. We waited until the last minute to rescue Social Security, and our backs were against the wall. We were forced to accept many stop gap measures.

I have prepared a full statement which I would like to submit for the record, if I may.

At this time, I would like to suggest and discuss briefly some Medicare financing reforms which would include complementary strategies: No. 1, health care cost control, which everybody, I am

sure, is going to dwell upon; two, additional Medicare revenues; three, Medicare cost-sharing and catastrophic protection reforms; four, improvements in the benefits structure.

We have already made proposals for Medicare and Social Security reform to the Democratic and Republican Platform Committees, and in my written statement to this committee I have given more details. But I will try to briefly summarize a few of the high points.

The principal one is to give support for the fundamental structure of the Social Security and Medicare Programs as a social insurance system. That is the way it was originally conceived. We oppose means tests in determining eligibility for benefits. Benefits are a right, in our opinion, derived from contributions paid during working years. Social Security and Medicare enjoy broad public support because they are insurance programs rather than welfare.

Second, we support universal Social Security and Medicare coverage. All Americans, including Government employees, should share in the responsibility as well as receive protection.

We support the insulation of Social Security and Medicare from short run political and budget pressures. A point that needs to be carefully considered is to remove the Social Security Administration from the jurisdiction of the Department of Health and Human Services and establish an independent agency to administer the Social Security and Medicare Programs. The makeup of the agency's governing board should be bipartisan, comprising citizens of stature who have demonstrated their concern for the future of Social Security and Medicare.

We believe in segregating and removing the trust funds from the Government's annual budget. Inclusion of the funds in the budget creates the illusion that the trust funds are available for other Government expenditures, and we oppose that view.

We believe that we should eliminate the wage base for ceiling for contributions and benefits for both employers and employees. As a minimum, such a measure should be adopted for Medicare part A. This spreads the financing burden more evenly and fairly across future beneficiaries. It would also allow high-technology employers to contribute a fair share to the programs, in contrast to the present situation in which they generally have small labor forces and a large percentage of their employees earn over the wage base ceilings.

We believe, also, Mr. Chairman, in the establishment of a minimum trust fund level of 6 months' expenditures. In January 1984, the trust fund level was equal to less than 3½ months' expenditures, which is not sufficient to avoid a financing crisis if the economy performs poorly.

We support efforts to restrain Medicare expenditures and control the escalation of private health care expenditures of older Americans.

The following proposals are similar to the recommendations of the 1982 Advisory Council on Social Security: Support the cost containment measures such as the option to choose coverage by a health maintenance organization and for new DRG prospective payment for hospital reimbursement systems for Medicare. We are concerned, however, that there must be adequate safeguards in the

new reimbursement system so hospitals do not prematurely release patients in order to squeeze greater profits.

One of the points I would like particularly to emphasize is that there are some people who fear that all our measures will mean less good care for the recipients of Medicare. We don't believe that is so. And we believe that it is a cunard to get people to refuse to adopt these reforms.

We suggest adopting prospective negotiating fee schedules for physician services covered by Medicare. We would require physician assignment for treatment of Medicare-covered services. As a minimum, physicians should be required to make an annual election whether or not they will accept assignment for all Medicare-covered patients. Incentives for physicians to accept assignments could and should be implemented.

Mr. Chairman, I think that summarizes, and I hope briefly, the main points that we would like to suggest at this time. And we are very grateful and would offer our full cooperation to you and your committee.

[The prepared statement follows:]

STATEMENT OF FORMER CONGRESSMAN JAMES ROOSEVELT, CHAIRMAN OF THE NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

The National Committee to Preserve Social Security and Medicare has outlined six principles which should guide the reforms to solve the Medicare Financing Crisis. A medicare rescue plan that violated these principles would destroy medicare rather than rescue it. From these principles, we have made fifteen specific recommendations. Our proposals are applicable to both Social Security and Medicare because they are complementary social insurance programs providing retirement income and health security to older Americans.

SUPPORT FOR THE FUNDAMENTAL STRUCTURE OF THE SOCIAL SECURITY AND MEDICARE PROGRAMS AS A SOCIAL INSURANCE SYSTEM

1. Oppose means tests in determining eligibility for benefits. Benefits are a right derived from contributions paid during working years. Social Security and medicare enjoy broad public support because they are insurance programs rather than welfare.

2. Support universal Social Security and Medicare coverage. All Americans-including government employees—should share in the responsibility as well as received protection.

SUPPORT FOR THE INSULATION OF SOCIAL SECURITY AND MEDICARE FROM SHORT-RUN POLITICAL AND BUDGET PRESSURES

3. Remove the Social Security Administration from the jurisdiction of the Department of Health and Human Services and establish an independent agency to administer Social Security and Medicare. Make-up of the agency's governing board should be bipartisan, comprising citizens of stature who have demonstrated their concern for the future of Social Security and Medicare.

4. Segregate and remove the trust funds from the government's annual budget. Inclusion of the funds in the budget creates the illusion that trust funds are available for other government expenditures.

SUPPORT FOR LESS REGRESSIVE TAXATION AND INCREASED USE OF GENERAL REVENUES RATHER THAN INCREASES IN PAYROLL TAX RATES

Payroll taxes should finance the majority of benefits because they establish the worker's claim for benefits. However, high payroll tax rates combined with a ceiling on the wage base are regressive and increase employers labor costs, particularly to small businesses and labor intensive industries. These measures would raise additional revenues.

5. Eliminate the wage base ceiling for contributions and benefits for both employers and employees. As a minimum such a measure should be adopted for Medicare

Part A. This spreads the financing burden more evenly across future beneficiaries. It also would allow high technology employers to contribute a fair share to the programs, in contrast to the present situation, in which they generally have small labor forces and a large percentage of employees earning over the wage base ceiling.

6. Consider use of general revenues to cover administrative expenses, as part of a failsafe stabilizer, and to cover increased financing of Medicare Part B.

SUPPORT FOR THE SHORT-TERM SOLVENCY OF THE TRUST FUNDS

7. Establish a minimum trust fund level of six months' expenditures.

8. Introduce a failsafe, automatic stabilizer provision in the event of poor economic performance.

SUPPORT FOR THE LONG-TERM SOLVENCY OF THE OASDI TRUST FUNDS

9. Oppose the reallocation of payroll taxes from OASDI to Medicare Part A in the mid-1990s. This suggestion of the 1982 Advisory Council on Social Security to reallocate tax rates casually undoes the work of the National Commission on Social Security Reform to ensure the long-term solvency of the OASDI trust funds. An adequate surplus in the trust funds will be necessary to pay for retirement benefits when the "baby boom" generations retires so the next generation is not burdened unfairly with higher payroll tax rates.

SUPPORT FOR EFFORTS THAT RESTRAIN MEDICARE EXPENDITURES AND CONTROL THE ESCALATION OF PRIVATE HEALTH CARE EXPENDITURES OF OLDER AMERICANS

The following proposals are similar to recommendations of the 1982 Advisory Council on Social Security.

10. Support cost containment measures such as the option to choose coverage by a health maintenance organization and for the new DRG prospective payment hospital reimbursement system for Medicare. We are concerned, however, that there must be adequate safeguards in the new reimbursement system so hospitals do not prematurely release patients in order to squeeze greater profits.

11. Adopt prospective negotiated fee schedules for physician services covered by Medicare.

12. Require physician assignment for treatment of Medicare covered services. As a minimum, physicians should be required to make an annual election whether or not they will accept assignment for all Medicare covered patients. Incentives for physicians to accept assignment could be implemented.

The following proposals oppose recommendations of the 1982 Advisory Council on Social Security because they do not help to control health care costs. Those Advisory Council proposals only shift the burden for health care cost increases to Medicare beneficiaries.

13. Limit the increase in Medicare Part B premiums to increases on the cost of living.

14. Oppose additional co-insurance for hospital care and nursing home services covered under Part A.

15. Oppose an increase in age of eligibility for Medicare.

Adoption of these proposals will help safeguard the current Social Security and Medicare programs. In addition to the above proposals we are examining improvements in the Medicare structure. Cost-sharing should be restructured and catastrophic protection added. The National Committee to Preserve Social Security and Medicare intends to work with the political parties, other organizations with interests in Social Security and Medicare, the Congress, and the Social Security administration to safeguard and improve Social Security and Medicare.

Chairman JACOBS. Mr. Roosevelt, we are grateful for your contribution to the record, particularly the novel or at least new idea about the consolidation of the elements of the Social Security Program and have them in one area. It is food for thought.

Mr. Duncan.

Mr. DUNCAN. I have no questions. Thank you, Mr. Chairman.

Chairman JACOBS. I believe Mr. Duncan was also a colleague of yours.

Mr. DUNCAN. Yes, sir. We discussed that earlier.

Mr. ROOSEVELT. Yes, sir.

Chairman JACOBS. So if there are no further questions, Mr. Roosevelt, you can stay or leave, whichever you wish, at this point, as your time requires.

Mr. ROOSEVELT. Unfortunately, I have an appointment with the Speaker, and if I don't keep it I will be in trouble.

Chairman JACOBS. Or maybe we will be in trouble.

Mr. ROOSEVELT. Exactly.

Chairman JACOBS. The worst thing he can give us is a 3 a.m. session, I guess.

Shall we proceed now with the panel in the order in which people are listed.

STATEMENT OF MELVIN A. GLASSER, DIRECTOR, HEALTH SECURITY ACTION COUNCIL, ON BEHALF OF THE HEALTH SECURITY ACTION COUNCIL, THE SOS COALITION TO PRESERVE SOCIAL SECURITY, AND THE NATIONAL EDUCATION ASSOCIATION

Mr. GLASSER. Thank you, Mr. Chairman.

I am Melvin A. Glasser. I am the director of the Health Security Action Council, and I am testifying for the council, which is a coalition of civic, labor, business and other organizations concerned with health care. I speak also for two specific members of our council: The Coalition to Preserve Social Security; and the National Education Association.

Mr. Chairman, I ask permission to have inserted in the record my full testimony, which has been placed with the committee staff, and shall attempt at this point to summarize that testimony. I ask permission to insert the full testimony in the record.

Chairman JACOBS. We will do that without objection.

Mr. GLASSER. Mr. Chairman, we have appeared before this committee on numerous occasions on this issue. I will say this without going into the numbers involved—you are well aware of it. But at this point we have had a very strange situation in which the administration has done very little to deal with the inflation problem and with the cost escalation problem, except to declare that it has disappeared.

The claim of the Secretary of HHS that the administration has broken the cycle of health care inflation is not supported by the facts. From a relative price perspective, hospital inflation is worsening. In 1972, CPI rose 9.2 percent, and hospital prices inflated 18 percent—double the overall rate. Last year's increase was 11.4 percent, which was triple the 3.8 percent BLS rate.

The Secretary of HHS tells us that in the first part of 1984, hospital prices increased only at the rate of 6.5 percent. She neglects to point out that this is almost double the annual 3.6 percent rate of the same period for the CPI, and that one hardly discusses or arrives at conclusions on prices based on the 5 months' trend. But if one looks at 18 or 19 months, it is quite different.

We find the same from the claims of the hospital industry. They suddenly discovered that it is not necessary to do anything about the problems in hospital cost inflation by using the same kind of extended reasoning that the Secretary of HHS does. Meanwhile, the private sector finds its costs doubling every 5 years.

Our system, we find, is in serious disarray. Part of the solution the Federal Government proposed is to pass more of the increasing costs on to the private sector. Well, the private sector has some response, and I hope in this discussion there will be some recognition of that.

Gerald Greenwald, vice chairman of the board of Chrysler Corp., testified recently, and I quote: "The single biggest disadvantage—outside of tax differentials and currency rates—that American car companies face versus the Japanese is not wages:"—not wages—"it is health care."

Mr. Greenwald went on to say: "It is going to take the cooperation of all parties to get us out of the health care mess."

But this is not the view of the present administration. They have repeatedly stated that their concern is primarily for the Federal budget. They have rejected any view that speaks to the interrelatedness of health costs regardless of who pays for them. They see their responsibility related to the budget—not to the costs being borne by American business, by American labor, by State and local governments, and by the consumers. They claim the new prospective payment system of medicare, the DRG's, provide the answers to health care cost containment.

Mr. Chairman, I would like to respond, if I may, to the question you raised of an earlier witness. We don't know what the effect is of the DRG system on costs. There is no meaningful evidence on either costs or quality that any credible researcher in health care will say to this committee that proves one thing or the other.

What we can say at this point is it is an interesting program; it may or may not have good results. Look at it over a period of time.

Now, rather than simply be opposed to a policy that says we will only look at the Federal budget and see how much we can transfer to others, our group and the organizations I represent are saying to you that there is a constructive plan that you heard about, H.R. 4870 from Mr. Kennedy this morning. This health cost containment plan makes eminent good sense. It is not a piecemeal plan. It is not a plan that says we will distort the evidence and say there is nothing wrong, things are going well.

It makes possible substantial budget savings from Medicare, Medicaid, and personal health services programs. It includes all providers of services—not only hospitals. It provides for savings in the private sector as well as the public. It encourages the States to participate in and run the plan. It provides new protection to private health insurance by putting an end to further cost shifting which is occurring, cost shifting from the public to the private sector, and from one insurance program to another.

It provides a mechanism to study and recommend curbs on the needless proliferation of medical technology estimated only 2 weeks ago to be responsible for 30 percent of the increase in inflationary costs in health care.

It gives the States more authority and it provides a means in a regular way of dealing with the issues which this committee has been struggling with for some years.

I hope, Mr. Chairman, that this committee will not attempt to deal with the problem again in a piecemeal, basically unsatisfactory way. The proposal of Mr. Gephardt and Mr. Kennedy has im-

perfections. There are lots of things that can be done better. But it has the virtue of being a comprehensive and intelligent and knowledgeable approach, and we sincerely hope this committee will look at it from that point of view.

Thank you.

[The prepared statement follows:]

STATEMENT OF MELVIN A. GLASSER, ON BEHALF OF THE HEALTH SECURITY ACTION COUNCIL, THE SOS COALITION TO PRESERVE SOCIAL SECURITY, AND THE NATIONAL EDUCATION ASSOCIATION

Mr. Chairman, and Members of the Committee, I am Melvin A. Glasser, Director of the Health Security Action Council. We are an organization of 100 distinguished Americans, working together, under the leadership of Chairman Douglas Fraser, with a coalition of labor, consumer, senior citizen, women's farm and youth organizations to reform the nation's health care system.

The views advanced in this statement are also supported by the SOS Coalition to Preserve Social Security and the National Education Association, two major national organizations participating in our program, which have very special concerns with the viability of the Medicare programs.

THE COST-ACCESS CRISIS

The term "crisis" is often used in connection with the Medicare financial situation. It is appropriate for both demographic and funding reasons. In 1980, there were almost 26 million persons past the age of 65. Continuous substantial increases are expected to bring the total of elderly Americans to 35 million by the turn of the century. Equally important is the fact that the numbers of persons over age 75 is increasing at a rate almost double that of the general population, so that by the year 2030, this group would constitute almost one in ten Americans.

The combination of increasing numbers of elderly, vulnerable and fragile elderly, and their concomitant increases in health care needs represent a clear and present danger which we believe this Committee, the Congress and the Nation needs to address.

Various responsible groups have made estimates as to the viability of the health insurance trust fund. Little can be gained from attempting to fine tune these estimates. There is general agreement that, unless there is substantial intervention in the health care system, the trust fund is likely to be exhausted sometime in the early 1990's.

A major factor in the increasing costs of providing health services to the elderly has been the runaway inflation in health care costs. Over the last decade, they have increased at a rate two to three times more rapid than the Bureau of Labor Statistics Cost of Living indexes.

It is startling to contemplate that payments for each Medicare enrollee grew 107 percent between 1977 and 1982, an average of 19 percent per year (Office of Technology Assessment report).

In recognition of the failure of a variety of partial and inadequate measures to control hospital costs and the fact that these are the major inflationary factor, the Secretary of Health and Human Services this summer simply declared victory over this cost escalation by fiat. Supported by officials of the American Hospital Association, she pointed out that the annual rate of increase in hospital prices was only 6.5 percent during the first part of 1984, while in 1981, at the outset of the current Administration, the annual increase was 15.1 percent.

The Administration used these numbers to support the claim that they broke the cycle of hospital cost inflation. The hospital industry has been appearing before committees like this one advancing the proposition that no further measures are therefore needed to control hospital costs.

They are both wrong, as members of this Committee are well aware from examining what is happening to Medicare costs. From a relative price prospective, hospital inflation is worsening. In 1975, the Consumer Price Index rose 9.1 percent, while hospital prices rose 18 percent—double the overall inflation rate. Last year's increase of 11.4 percent was triple the Consumer Price Index increase of 3.8 percent.

The Secretary of Health and Human Services tells us that, in the first part of 1984, hospital prices increased only at the rate of 6.5 percent. She neglects to point out that this is almost double the annual 3.6 percent of CPI for the same period.

The Administration, with the concurrence of Congress, claims its actual and approved future plans will have cut back the costs of Medicare over $20 billion in a five year period. Much of the so-called savings are at the expense of program beneficiaries, as the sick elderly and severely disabled are forced to accept increased costs, deductibles, and co-payments. More are in prospect.

Meanwhile, the private sector finds its costs almost doubling every five years. Our health care system is in serious disarray. Part of the solution the federal government proposed is to pass more of the costs onto private employers and state and local governments. This latter group is rarely mentioned, though the increased costs of health insurance premiums for their employees are a major financial drain on hard pressed state and local government budgets.

The buck, however, doesn't stop there. In the last three years, private sector workers, school teachers and administrators, and other public workers have been forced by employers to accept increasing co-payments and deductibles and reduced insurance protection. All this, of course, saves no money. It simply transfers payments. This is poor public policy. It's at least part of the reason the Medicare trust fund is in trouble.

Gerald Greenwald, Vice Chairman of the Board of the Chrysler Corporation, testified only recently: "The single biggest disadvantage (outside of tax differentials and currency rates) that American car companies face versus the Japanese is not wages: it's health care."

Mr. Greenwald went on to say: "It's going to take the cooperation of all parties to get us out (i.e. of the health care mess)."

But this has not been the view of the present Administration. They have repeatedly stated their concern is primarily for the federal budget. They have rejected any view that speaks to the interrelatedness of health costs, regardless of who pays for them. They see their responsibility related to the federal budget but not to the costs being borne by American business, labor, state and local governments, and the American people.

Thus the answers they propose to Medicare's and the nation's health problems have done little to stay the costs of out-of-control health inflation.

Reducing benefits, making it harder for the poor to get care, introducing "competition", "cost-sharing", forcing beneficiaries to give up all or part of their insurance, preferred providers, have all been tried or are being tried, thus far with little impact.

In recent weeks, the American people have been treated to a new public relations campaign promoted and endorsed by administration spokesmen and hospital industry advocates. They claim the new prospective payment system of Medicare (DRG's) provides the answer to health care cost containment. This may or may not be true, but what is true is that meaningful evidence does not exist for an untried system, barely a year old, involving only a part of the patient population and fewer than half of Medicare patients.

AN AFFIRMATIVE PROGRAM

Having pointed out the problems with the short-sighted and largely failed approaches to controlling Medicare's costs, we urge the Committee to consider a comprehensive plan which would cover the principal elements which affect costs: hospitals, physicians and other professionals, laboratory and x-ray services, health maintenance organizations, and new procedures and technology. Nursing homes would also be included if feasible. Effective cost containment cannot be achieved by trying to save money in one sector, like hospitals, or in one program like Medicare. This approach only results in shifting to the other elements or programs.

Furthermore the plan should recognize the interrelatedness of public and private health care programs. Provision should be made, therefore, as it must be, to bar cost escalation and cost-shifting from the public to the private sector and vice versa.

Further, as the current political debate heats up, there is much discussion of protecting the cash benefits of the elderly Social Security recipients. But scant attention is being paid to the fact that this cherished income is being eroded by constantly increasing premium costs, co-insurance, deductibles and provider overcharges.

The Congress and the Administration cannot and should not be engaged in the charade of claiming to save money by reducing payments for certain services in Medicare through shifting them onto private insurance, private employers or patients.

The Health Insurance Association of America, for example, estimates that $8.8 billion in Medicare charges will be shifted onto private sector insurance in 1984. It's time Congress called a halt to this "robbing Peter to pay Paul" game.

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The plan we commend to your attention, which we believe makes eminent good sense and which provides a constructive means of dealing with Medicare financial problems, has as its principal sponsor in the House, Representative Richard Gephardt, and is contained in H.R. 4870, the Medicare Solvency and Health Care Financing Reform Act of 1984.

This is a two-stage phase program. Phase I becomes operative ninety days after the legislation is passed. In this phase, permissible health services price increases are halted while the states are given a two-year period to develop and put into operation a continuing cost containment mechanism.

If a state is unable or unwilling to develop a plan which meets the criteria in the legislation, the federal government would be authorized to step in.

During Phase I, hospitals would be required to limit their annual budgets to total inpatient revenues in the previous year, or a model year in one of the past three years, plus the increase in "market basket" index for hospital operating costs between the previous year and the current year.

Similar limitations would be placed in Phase I on expenditures for physicians and other professional providers, lab and x-ray services and health maintenance organizations. The Secretary of HHS would be required to conduct a study and report on the feasibility of containing nursing home costs in a manner similar to that described for hospitals.

A national professional Advisory Committee on New Procedures and Technology would be established. It would have independent authority and staff and would advise the federal government, the states and private sector insurers on the efficacy of new and existing medical technology. Little attention has been paid to health technology assessment. This is unfortunate. In the last decade alone, it is estimated to have contributed to 30 percent of the cost inflation increase. The plan we are urging the committee to support would also encourage the development of alternate delivery systems. For example, at the state level, contracts would be negotiated separately with health maintenance organizations. They would become an integral part of the health system.

Phase II would become operative after two years and would give each state control over its health cost programs, within established federal limits.

A hospital prospective budgeting system would be required for each participating state. The state would be required to hold total expenditures for hospitals to the previous year's expenditures within the state, plus the increase in the "market basket" index.

The states could, as long as they remained within the predetermined ceilings, use their own methods of determining how to pay hospitals within the system. This could be done in a variety of ways: Prospective budgeting by category of hospital, (e.g. teaching hospital, small, medium, or large community hospital, rural hospital, etc.); formulae to set limits on institutions could charge various payors; budget reviews of each hospital; capitation payments for defined populations. (This program could also encourage testing, on a comparative basis of the developing DRG (Diagnostic Related Groups) prospective payment program.)

A number of states have already had considerable success in holding down increases in health care costs through mandatory state commissions.

Physicians and other Professional Providers—Reimbursement arrangements, including fee schedules, would be based on negotiated agreements by the providers with the state agency. Representatives of Medicare, the prepayment organizations, and consumers would be part of the negotiations.

Laboratory and X-ray Services—A laboratory and x-ray payment committee under the state agency, and consisting of representatives of the public agency, Medicare, laboratory and x-ray providers, insurance companies and consumers, would negotiate annual reimbursement schedules. The committee would be empowered to review and set standards for appropriateness and frequency of the procedures and technology use.

WHAT H.R. 4870 WOULD DO

1. Make possible substantial federal budget savings for Medicare, Medicaid and other personal services programs for the next year, and for subsequent years. This, however, would be achieved without further slashes in benefits and eligibility.
2. Provide for comparable savings for private sector health insurance.
3. Encourage states to participate in and run the plan, and receive incentive payments in the form of reductions in the required Medicaid matching funds.
4. New protection would be provided to private health insurance by putting an end to further cost shifting.

5. The states would have substantially increased authority, within federal guidelines, to control all health care costs within the state.

6. The plan would make possible, over the next two years, a system to contain health care costs in an orderly way. The frantic, haphazard annual efforts by the Congress to effect needed savings would largely be avoided. Program planning and rationalization of services would be encouraged and would be related to necessary fiscal constraints.

A COMPREHENSIVE PROGRAM

H.R. 4870 commends itself to us, as I believe it should to you, because it covers the public and private sectors, it places much of the responsibilities on the states, and recognizes that every principal aspect of health care costs should be incorporated in a meaningful cost containment plan. Therefore, it recognizes and brings within the scope of the legislation not only hospitals, but also nursing homes, physicians and other professional providers, laboratory and x-ray services, health maintenance organizations, new procedures and technology, and long-term care.

Its provision for a two-year phase-in period and for substantial negotiations between payors and providers, with consumers represented, adds a new and needed dimension to health programming.

Our major regret is that, because H.R. 4870 is proposed as a cost containment plan, it does not extend eligibility for care to tens of millions of Americans now without such protection, nor does it provide for new needed benefits in present programs. It is our hope, however, that once it begins to achieve what we believe are its realistic goals, there will be new opportunities for extending eligibility and benefits.

H.R. 4870 begins to put into place sound long-range plans for continuing restraint on health cost increases in both the public and private sectors. It may well put into place the needed answer to long-term Medicare solvency. It brings together the principal parties in the health care program in annual negotiations designed to work out state and local cost containment issues. It is a consumer-oriented plan which is realistic and achievable. As such, it merits support by all Americans. It is a constructive alternative to cost containment efforts which until now have been tried and have failed.

Chairman JACOBS. Mr. Duncan.

Mr. DUNCAN. I have no questions. Thank you, Mr. Chairman.

Chairman JACOBS. Mr. Hutton.

STATEMENT OF WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. HUTTON. I am Bill Hutton, National Council of Senior Citizens. You have my full statement; perhaps I can spend a few moments highlighting some of the issues which we are seriously concerned with.

The National Council of Senior Citizens represents over 4½ million older people through 4,500 clubs in State and area councils throughout the country. We are very concerned about this spiraling cost of medical care because it threatens both Medicare solvency and the elderly's health and income security.

To slow the rising cost of medical care we advocate comprehensive reform toward the cost-effectiveness of the entire health care system—not just the Medicare Program. We believe the proposed Reform Act of 1984, cosponsored by Senator Kennedy and Representative Gephardt, can achieve that goal. And we believe that the two major objectives of this bill—the solvency of Medicare and the across-the-board restraint of medical costs—are absolutely vital.

The Kennedy-Gephardt bill is designed to achieve its objectives in both the short term and long term without cutting Medicare benefits or increasing taxes. It would do so through a balance of Federal and State regulations, through public and private sector

initiatives and innovations, and through financing and delivery reforms. So I think this is important.

It also provides for a residual Federal program to assure that a minimum plan is established nationwide.

The last factor I believe is very important. It distinguishes the plan from those which rely on voluntary compliance.

Today, maybe I will limit my oral remarks just to two major issues: one, the senior citizens' reaction to the problems of rising medical costs and Medicare's threatened insolvency; and two, the reasons that the National Council of Senior Citizens advocates adoption of the Kennedy-Gephardt bill.

The problems of rising costs and their consequent erosion of insurance protection are not new to seniors. Attachment A of my written statement contains excerpts from some of the many letters we receive from our members. I would say that the senior citizens of this nation are far more aware of the crisis in health care costs and Medicare than most other people. The elderly experience these problems first-hand and live with them every day.

Senior citizens are the ones who must stretch their limited incomes to pay for prescription drugs. They are the ones who know how hospital information reaches deeply into their pockets through the $356 part A deductible. Seniors live in fear that not only is their health threatened with advancing age, but now their Medicare protection is threatened by Congress' failure to enact needed reform.

We are talking about older people being fearful about costs and medical insolvency. I noted that in Dallas recently, HHS Secretary Margaret Heckler stated in a press conference that fear is a function of growing old. God forbid.

We believe that Congress must understand the factors involved in Medicare's revenue and outlay trends. Listen to the experts and then weigh the variety of alternatives proposed. But you must also listen to the people who are not in this room today. And it would have been fairly easy to fill it. But my senior citizens from around here in Washington are joining thousands of other senior citizens across the country today who are not only becoming increasingly alarmed but they are frustrated by Congress' failure to enact cost-containment, and they are angry that the President and the Congress increased their out-of-pocket costs instead of adopting long-term solutions to the problem.

So in 90 cities and towns, and 37 States, many thousands of our members and their friends are participating in Senior Health Care Day. I would like to just demonstrate our bumper sticker: "Caution: This Election May Be Hazardous To Your Health." We have taken that across the country today, and you will no doubt be seeing something of it, Mr. Chairman.

Chairman JACOBS. Is that directed to the candidates or to the——

Mr. HUTTON. It is directed to the people. It says, "Protect yourself; register and vote." We hope that that is what they are going to do, Mr. Chairman.

Chairman JACOBS. Gotcha.

Mr. HUTTON. One way to address this crisis, obviously, is to enact the Kennedy-Gephardt Medicare Solvency and Health Care Financing Reform Act. I know the committee is capable of approving that,

but somebody has to start somewhere, and now is almost already too late.

The administration is looking forever out of the window doing nothing but telling everybody what a wonderful job they have been doing.

Now we look forward to further hearings on this bill, and at this time we will bring our people along.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. Chairman, I am William R. Hutton, Executive Director of the National Council of Senior Citizens. The Council represents over 4.5 million older persons through 4,500 clubs and state and area councils throughout the country. NCSC is seriously concerned about the spiraling cost of medical care and its threat to Medicare solvency and the elderly's incomes.

Our members, who live on reduced incomes in retirement, express extreme frustration at the ever-increasing medical bills they must pay in spite of having Medicare "coverage." Based on their experience during the last three years, they are fearful that Congressional action to forestall Medicare's threatened insolvency might increase their costs and not permanently solve the problem.

To slow the rising cost of medical care, the National Council of Senior Citizens advocates comprehensive reform toward the goal of cost effectiveness in the entire health care system for the benefit of all citizens. We believe that the Medicare Solvency and Health Care Financing Reform Act of 1984, co-sponsored by Senator Edward Kennedy (S. 2424) and Representative Richard Gephardt (H.R. 4870), can achieve this goal. This bill has two major objectives: the solvency of Medicare and across-the-board restraint of rising medical costs.

The Kennedy/Gephardt bill is designed to achieve effective and comprehensive cost containment in both the short term and long term without cutting Medicare benefits or increasing taxes. It would do so through a balance of Federal and state regulations, public and private sector initiatives and innovation, and through financing and delivery reform. It also provides for a residual Federal program to assure that a minimum program is established nationwide.

Representatives of the National Council of Senior Citizens have testified before this committee on numerous occasions. In recent years, we have presented testimony concerning the Medicare-related issues of highest priority to senior citizens. We have asked the members of the committee to address these issues.

In summary, in our testimony we have stated:

The cost of medical care in this country is rising at a rate far in excess of the return the investment gives us. A nation which spends $360 billion annually on health care and fails to serve adequately as many as 40 million citizens has an inefficient and inequitable system. We ask policy-makers not to look so much at total health spending, but at the product we are buying and the price we are paying.

Effective control over medical expenditures can occur only through a plan which reforms third-party payment and delivery of service. It must be applied to all public and private insurors and provide for control over capital expenditures. Such an approach must include spending limits and built-in mechanisms that assure access, fairness, quality, and efficiency. It must not discriminate against particular providers, insurors, or consumers.

The threat of Medicare's Hospital Insurance Trust Fund insolvency is directly related to the larger health system's costs and inefficiences. We cannot secure Medicare solvency without confronting the growing national health crisis. Therefore Congress must solve Medicare's financial problems through a system-wide cost-containment plan.

The Reagan Administration's policies have failed to address the system-wide problems and have been focused on cutting back the Medicare budget instead. While these efforts may have slowed the outflow from the trust funds somewhat, they have exacted a heavy financial burden on the Medicare beneficiaries. Since the policy does not produce cost containment in the health system, medical inflation is still rising at rates double the CPI.

We caution against being fooled by the recent moderation in medical inflation or proclaiming that DRGs have solved the problem of rising hospital costs. This moderation is due much more to the drop in the CPI than to Administration policy.

To accept current inflation levels as indications of success and deferred need for system-wide reform could be disastrous. We still use the same inefficient delivery and financing mechanisms as we did when inflation was higher.

The growing burden of out-of-pocket health spending due to inflation, Medicare budget reductions, and lack of coverage for necessary services threatens senior citizens' income security and access to medical care. The longer Congress waits to enact systemwide reform the greater the burden will be on the people we represent. (I refer you to Attachment A of my written statement. It includes exerpts from some of the many letters our members send us complaining about the cost of health care and Medicare's failure to meet their needs.)

We need reform of the system, not new ways for beneficiaries to finance their care. For example, increasing beneficiaries' cost-sharing levels and possibly linking them to income is not cost containment. It is simply forcing someone else to pay the government's bills because the government failed to control expenditures.

Today I will limit my oral remarks to two major categories: Senior citizens' reaction to the problems of rising medical costs and Medicare's threatened insolvency; the reasons that the National Council of Senior Citzens advocates Congressional adoption of the Kennedy/Gephardt bill.

Senior citizens are the people more in need of frequent and multiple medical services and are more seriously affected by both rising costs and reduced insurance coverage than any other group. The problems of rising costs and their consequent erosion of insurance protection are not new to seniors. They live with these problems every day. Our members' letters point this out clearly: (the price of) "Medicine goes up every time I get a prescription filled." "I stay under a doctor's care all the time. Between doctors and my medicine, I spend a great deal of money each month."

I would say that the senior citizens of this nation are far more aware of the crises in health care costs and Medicare than any other people. The Congress, budget and health policy experts, and others are certainly aware of the problems and the threats they pose. However, senior citizens experience these problems firsthand.

Senior citizens are the people who must stretch limited incomes to pay for prescription drugs. They are the ones who know how hospital inflation rates, which this year increased the Part A deductible by 17 percent, reach deeply into their pockets. The senior citizens of this nation are the ones who live in fear that not only is their health threatened with advancing age, now their Medicare protection is threatened by Congress' failure to enact needed reform in the health system.

Today's hearing is indeed timely. You have gathered a wide variety of witnesses from the Congress and government, the health industry, insurors and workers, consumer representatives and others. We are very pleased that our positions and recommendations are being heard. The members of this committee and your Congressional colleagues will then have both the opportunity and the responsibility to adopt carefully crafted, long-term solutions.

To solve the health care and pending Medicare crises, we believe Congress must undestand the factors involved in Medicare's revenue/outlay trends, listen to the experts, and weigh the variety of alternatives proposed. But that would be only half of the job to be done. We ask you also to listen to those who are not in this room today.

I speak of the thousands of senior citizens across the country who are becoming increasingly alarmed at their rising medical bills; the senior citizens who are frightened by the talk of Medicare's certain financial crisis; the senior citizens who are frustrated by Congress' failure to enact cost-containment measures for so many years; the senior citizens who are angry that the President and Congress increase their out-of-pocket spending rather than adopt long-term solutions.

Senior citizens may be upset and scared, but they are not sitting still. There is a tremendous momentum building out of their frustration. They want action from their elected representatives, and they are bringing their issues "to the streets."

Not since the early 1960's when thousands of older people rallied in Madison Square Garden and in the streets outside, have we seen the kind of anger and fear now building among senior citizens and their allies. The grassroots support and the demand for change are growing rapidly.

Today, in fact, in 90 cities and towns in 37 states, thousands of senior citizens and their friends are participating in "Senior Health Action Day." They are taking the Medicare financing crisis issue to the Presidential and Congressional candidates. Throughout the country, senior citizens are saying: "There is a health care crisis which is hurting us and our families and it must be addressed in the upcoming elec-

tion." They are demanding solutions from those now in office and those hoping to be elected.

It is in this climate that we meet today. The older people of this nation are sending their message to the Congress, to Candidates for office and to the public. They are not just trying to bring attention to the crisis. They are asking for enactment of fair, effective and responsible solutions.

One of the solutions, we believe, will be the Kennedy/Gephardt Medicare Solvency and Health Care Financing Reform Act of 1984. I will now identify some of the reasons we believe the bill is the best solution currently before the Congress.

The Kennedy/Gephardt bill is the only proposal we can see that would meet specific criteria and provide for certain elements we believe are critical to Medicare solvency legislation.

The bill recognizes that Medicare's financial problems are directly related to the problems of cost and inefficency in the larger health care system. Kennedy/Gephardt calls for financing and delivery reform rather than mere "financing" of an already flawed system. This incidentally is one of the major failings of the Advisory Council on Social Security recommendations. The Council members devised methods to put more money into Medicare (too much of it from the beneficiary) rather than institute reform to achieve savings through efficiency.

H.R. 4870 would limit the rate of growth in the cost of hospital and physician services. Putting a lid on both sources of rising costs is the key to health system savings, Medicare solvency, and beneficiary financial protection. Hospital expenditures account for three-fourths of Medicare's outlays. Hospital costs account for the large "up front" cost of $356 paid by the older individual who needs hospitalization. In addition, effective spending control must include the "spender." Physicians make 70 percent of health services usage decisions. Thus our doctors affect national health spending not only through their fee levels, but even more so through the services they prescribe.

The proposal seeks to assure Medicare solvency through measures which do not include increasing beneficiaries' out-of-pocket spending or decreasing their benefits. To cut benefits from a health insurance program which fails to cover more than one-half of its beneficiaries' costs would be disastrous aging, health, and social policy. To raise cost-sharing levels is not cost containment nor does it require provider efficiency through reimbursement limitations. It just asks the elderly to pay more of the government's bill, when the government should be taking steps to moderate the health bills of all Americans.

H.R. 4870 applies to public and private purchasers of health care. National health expenditure rates will never be controlled by limiting payments of some insurors and not others, or by not applying cost-containment measures to all major providers. Even Medicare's prospective payment to hospitals, potentially effective because it limits payment, cannot yield the savings needed in the system. The plan applies only to Medicare and does not yet include other providers. I would add that the recent moderation in hospital costs should not be misconstrued as a victory of DRGs over inflation. We believe that such credit is premature. Moreover, as much as two-thirds of the drop in hospital prices can be attributed to the decreased CPI of our recession economy.

The plan would reform payment mechanisms of all payers and give providers incentives to render care efficiently and provide only that level of care which is necessary. This element is vital to cost containment which meets social policy criteria. That is, we need to save money but not sacrifice fairness, access, quality, or national health. There certainly are many so-called cost-containment plans in operation or in planning stages throughout the country. Too many of them, however, save money through bargaining, discounts, and price competition. They do not mandate that providers operate efficiently, and they allow discrimination or risk selection.

By including physicians in the plan and requiring them to accept Medicare payment levels as payment in full (assignment), H.R. 4870 provides multiple benefits to senior citizens. The plan addresses cost problems on both sides of Medicare. Although it is the Hospital Insurance Trust Fund which is being bankrupt by hospital inflation, Part B, the physicians' side of Medicare, poses equally serious threats to older people. Part B, or Supplementary Medical Insurance, though considered "optional" by many people, is the elderly person's vital access point to health care. However, it is also the part of Medicare which is funded by high levels of beneficiary cost sharing ($176 premium, $75 deductible, and 20 percent co-payment). Because of physicians' charges in excess of Medicare reimbursement levels (non-assignment) and the limited services reimbursed, Part B covers only 56 percent of charges for physician and related out-patient services. Thus beneficiaries need the benefit of a plan which requires physicians to accept assignment. They also need the benefit of

control over physician fee increases. These increases, plus the growing number of services provided, are pushing up Part B program costs by 18-19 percent annually. Since 75 percent of the program's outlays are derived from general revenues, Part B has been the target too frequently of Federal deficit and budget reduction plans which shift costs to the elderly. The Kennedy/Gephardt plan is a much fairer approach. It saves Federal Medicare dollars by including physicians in cost containment. The plan calls for delivery reform. One of the most widely acknowledged problems of our health care system is that it is biased toward the more expensive institutional and technologically-oriented services. When the use of such services exceeds the medical needs of the individual, we are not using our health care dollar efficiently. Since payment mechanisms determine the nature of services utilized, we believe that H.R. 4870 will encourage the delivery of non-institutional or alternative methods of delivery which foster efficiency and maintain quality.

The bill recognizes a vital role for states in controlling health care expenditures. States which have all payer systems of cost control have demonstrated savings. Unless there is a Federal mandate for all states to develop such programs, we cannot achieve the savings we need throughout the system. H.R. 4870 allows states flexibility to develop plans best suited to their needs while meeting Federal guidelines. It also provides for a residual Federal program to assure that a nationwide system is maintained if states do not develop plans which meet Federal criteria.

In closing let me reiterate that the National Council of Senior Citizens believes that it is time for health care reform for the benefit of all Americans. On behalf of senior citizens, we ask Congress not to "finance" Medicare's problems, but to solve them. To do that requires a change in the way we do business throughout the health care system. We believe that H.R. 4870 will do just that.

We are asking Congress, therefore, for a commitment and for action. If Medicare's financial crisis has been postponed because of recent short-term budget cuts, that does not mean the problem has gone away. The sooner that remedies can be enacted, the better off will be millions of citizens—young and old.

[Attachment A]

SENIOR CITIZENS' COMMENTS ON MEDICARE AND HEALTH CARE COSTS

Quotes from letters to the National Council of Senior Citizens:

"Medical costs (doctors and hospitals) are getting way out of hand . . . Medicare is going broke, so we are told, trying to help pay for some medical costs. . . . Is there no limitation on doctor and hospital charges?"

—Oldham, South Dakota.

"Medicine goes up every time I get a prescription filled."

—Marshalltown, Iowa.

"I am 96 years old. . . . I have been with Medicare since it started . . . the $356 deductible is taking advantage of us . . . as the hospitals are the same and the care no different, so what is wrong?"

—Remer, Massachusetts.

"Medicare is headed for bankruptcy. . . . Couldn't this be largely due to inflation with the U.S. Congress to blame for not having enacted legislation to bring inflation under control? It's certainly not our fault."

—Pittsburgh, Pennsylvania.

"I stay under a doctor's care all the time. Between the doctors and my medicine, I spend a great deal of money each month."

—Baton Rouge, Louisiana.

"It seems as though someone needs to put a ceiling on hospital and doctors charges . . . our health is on the decline, therefore, it takes more for medicine and doctor bills than when we were younger. . . . We are trying so hard to be independent."

—Rome, Georgia.

"I only draw $342.00 a month so I take it to buy my medicine and hardly have enough to live on."

—Koscuisko, Mississippi.

"I hope and pray that Social Security and all other programs for the elderly will continue to be a blessing for all of us senior citizens."

—Ventura, California.

Chairman JACOBS. Thank you, sir.

Mr. Hacking.

STATEMENT OF JAMES M. HACKING, ASSISTANT LEGISLATIVE COUNSEL, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. HACKING. Thank you, Mr. Chairman.

I am Jim Hacking, assistant legislative counsel for the rapidly growing and now 16.7 million-member American Association of Retired Persons. I will submit the association's statement for the record and keep my remarks as brief as possible.

AARP's charge is to secure the enactment of legislation that would address Medicare's financial problems through a systemwide approach. By any measure, this country is facing a major cost escalation crisis in the health care marketplace. In 1982, we spent $332 billion on health care. That compares to a mere $51 billion in 1967. In 1982, we allocated 10.5 percent of the Nation's gross national product to health care, as compared to only 6.7 percent in 1967.

That was so despite the fact that GNP more than doubled over the period. The rate at which we spend for health care is currently $1 billion a day and the forecast is that by 1990, we will be spending $2 billion a day.

The effects of the cost escalation trend are abundantly clear. Medicare's costs are rising at an annual average rate of 18 percent; the hospital insurance, Part A Medicare Program, is projected to be insolvent sometime around 1991, and that program's deficit will accumulate to an estimated $162 billion by 1995.

It must be understood that Medicare is primarily a program that transfers wealth to hospitals and helps defray the cost of physicians' services. As such, Medicare and Medicaid are important components of this country's public and private third-party payment structure which is awesome in terms of the efficiency with which it transfers wealth from society as a whole to hospitals and physician providers of medical care.

Escalating health care costs are driving up the Federal budget deficits and crowding out other budget priorities. What has been happening with respect to Medicare is reflected in the private sector by the extraordinarily rapid rate of increase in premium costs of private employer-sponsored health plans that cover workers and their dependents.

If current cost escalation trends continue, a rapidly increasing proportion of the population, both young and old, will be either shut out of access to needed hospital and physicians' services, or will be financially impoverished as a result of having to use those services.

What kind of short-term options for dealing with the immediate care problem are there? The options fall into three basic categories: First, raise revenue through increased earmarked taxes. Second, shift costs off the program onto elderly and disabled beneficiaries. Third, and finally, impose a constraint that will limit the rate of increase in payments to hospitals and physicians and bring provid-

er cost increases more into line with increases in the Consumer Price Index.

AARP's position is as follows: We are opposed to options that merely shift cost to beneficiaries or dump more revenue into Medicare. Such options merely change the mix of who pays and merely transfer still more of society's wealth to hospitals and physicians without dealing with the fundamental health care cost escalation problem.

This is why AARP reacted so negatively to the recommendations of the Advisory Council on Social Security, because the Council was unwilling to adopt a systemwide approach and instead confined its attention to Medicare alone. That left the council inevitably with a menu of cost shift and revenue raising options from which it had to choose.

The problem is those options don't solve Medicare's fundamental cost escalation problem. We, as you might expect, have endorsed the Kennedy-Gephardt-sponsored Medicare Solvency and Health Care Financing Reform Act of 1984. It may not be perfect, but it would adopt the all-important systemwide approach, and it would impose the kind of short-term constraint that we espouse with respect to the rate of increase in payments to providers.

It would also carve out a major role for the States in assuring that institutions within their jurisdictions conform to reasonable revenue limits.

As a final point, we at AARP believe that the problem of health care cost escalation and the ancillary problem of Medicare's impending financial insolvency should be addressed next year in the context of the Federal budget process.

That concludes my remarks, Mr. Chairman. Thank you.

[The prepared statement follows:]

STATEMENT OF JAMES M. HACKING, ASSISTANT LEGISLATIVE COUNSEL, AMERICAN ASSOCIATION OF RETIRED PERSONS

Thank you, Mr. Chairman, for the opportunity to share with this Committee the American Association of Retired Persons' (AARP) deep concern about what is happening in the health care sector of the economy. The persistence of double-digit cost-escalation in the health care marketplace has placed an increasing burden on health care consumers, both young and old alike. The Medicare program is in jeopardy as well as comprehensive coverage under private insurance plans. Because health care cost escalation is not a new phenomenon, some have become anesthetized to the short and long range consequences of this trend. AARP has not; we recognize that if health care costs, especially hospital costs, continue to escalate as they have, accessible and affordable health care services will cease to be available to millions of Americans—not just the poor, but the elderly and millions of workers and their dependents, too.

AARP commends this Committee's leadership in exploring this difficult and politically sensitive issue. The Association's testimony today will consider five principal issue areas:

1. The growing problem in the health care marketplace;
2. The impact of cost escalation on Medicare and private health insurance;
3. The high out-of-pocket costs the elderly must pay for health care; and
4. AARP's policy proposals to fashion a more rational, less cost escalating health care system over the short and long term.
5. AARP's views of the major proposals to address health care cost escalation.

GROWTH IN THE HEALTH CARE SECTOR

The health care industry is one of the nation's largest and fastest growing economic sectors. Between 1967 and 1982, total national health expenditures increased

sevenfold from $51.3 billion to $322.4 billion—that is a spending rate of over $1 billion per day. Health care spending has also been taking a larger share of the nation's total resources—rising from 6.4% of GNP in 1967 to 10.5% in 1982.

This rapid growth in health expenditures has occurred because inflation in the health care sector has significantly outpaced general inflation in the economy for quite some time. Hospital costs are the leading factor in the health care cost spiral. Since 1967, the general (all items) CPI has increased by 198%, whereas hospital room rates have increased by 520%, about two and one-half times greater than the increase in the general CPI (Chart 1). Although not quite as dramatic as the rate of hospital cost increases, physicians' fees have also significantly outpaced the increase in the general CPI. Since 1967, the physician fee component of the CPI has increased by 252%.

Hospital expenditures are not only rapidly increasing, they are also the largest component of personal health care expenditures. Hospital expenditures have grown from $13.9 billion in 1965 equalling 39% of all personal health care expenditures that year to $135.5 billion in 1983, equalling 47% of personal health care expenditures.

Despite the sharp decline in inflation since January 1983, health care costs have continued to escalate at unacceptable rates. In 1983, general prices increased by only 3.2% whereas medical prices increased by 8.7% or more than twice as fast. Hospital room rates continued to be the leading factor in health care inflation. In 1983, hopsital room rates rose 11.3%, a rate of increase more than three times greater than the increase in the general CPI.

The tremendous growth in health care expenditures is expected to continue in the future. Unless the current health care financing and delivery system is changed, by 1990, total health spending will reach $757.9 billion, more than double what it is today. Even with the enactment of the Medicare prospective payment system, hospital outlays under Medicare Part A will increase by 11.5% a year between 1985 and 1995. Of this projected increase, 7% is attributed to the increasing price of hospital care, 2% is attributed to increased admissions, 1.5% is attributed to the increase in the size of the eligible population.

The health care inflationary trend has serious consequences for the federal budget. In 1982, the federal government spent $93.2 billion on health—$9.5 billion more than the year before, and $87.7 billion more than in 1965. Federal health expenditures (tied as they are to private sector prices for health care services), if left unchecked, will continue to escalate to over $231.6 billion in 1990—equalling more than 30% of all expenditures for health care in that year. Clearly, the trend in federal spending for health care is creating upward pressure on federal budget deficits and crowding out other budgetary priorities.

FACTORS CAUSING RAPID GROWTH IN THE HEALTH CARE SECTOR

The most important factor fueling the growth in the health industry has been the expansion of cost-based, third-party reimbursement. The third party payment system had its inception during the Depression. At that time insurance plans were designed in this manner to enable hospitals to remain financially solvent during times when increasing unemployment and decreasing wages made it difficult for workers to pay for unexpected hospital stays. The provision of health insurance protection, patterned after these early hospital insurance plans, grew during the 1940s and 1950s in response to several factors, including:

1. The exclusion of health insurance from World War II wage controls;
2. The inclusion of health insurance benefits as compensation in the collective bargaining process; and
3. The favorable tax treatment of employer-paid health insurance premiums.

Consequently, third-party reimbursement became the widespread mechanism to finance the high cost of hospital care.

Even before Medicare, hospital costs had demonstrated a pronounced tendency to rise at rates higher than prices in general. Between 1950 and 1965 the CPI showed an increase in the costs of semi-private hospital rooms of 2½ times, whereas the general level of prices rose the same period only by one-third. The adoption of third-party payment procedures by the government through Medicare and Medicaid only made matters worse.

Third-party payments now account for over two-thirds of all personal health care expenditures, about 90% of all hospital expenditures, and almost two-thirds of the expenditures for physician services.

Cost-based, third-party payament procedures are inherently inflationary. Hospitals are generally paid either on the basis of costs (what the hospital spends to pro-

vide goods and services) or charges (the amount a hospital bills for the goods and services it provides). As a result, there is no incentive to restrain spending since more spending means greater revenues. Similarly, physicians are paid according to the charges they establish for provided services. Therefore, the more services physicians render, the more compensation they receive. Moreover, unlike purchasing other goods and services, physicians, rather than consumers, determine both the quantity and prices of services rendered, including the necessity of a hospital admission and where it will take place. The consumer plays virtually no role in this process. Instead, providers are rewarded with more and more income for giving more and more care, and for acquiring more and more costly, technically sophisticated plant and equipment, whether or not such activities are necessary or beneficial. In addition. Because reimbursement favors institutional care, physicians overutilize hospitals, the most expensive component of medical care.

In 1983, Congress passed legislation to change the way Medicare pays for hospital care in an attempt to alter inflationary incentives inherent in traditional third-party payment procedures. Under the newly created DRG payment system, Medicare will pay hospitals a pre-determined price for each hospital stay. While Medicare's move to prospective payment is a step in the right direction, AARP seriously questions its effectiveness in controlling system-wide escalation in health care costs. Because the DRG system applies only to Medicare, hospitals can charge higher rates to private payors in order to regain lost Medicare revenues. Total costs remain the same; the burden of paying these costs is just shifted among payors. In addition, the yearly rate of increase in DRG payments remains tied to a system-wide measure of hospital inflation. To the extent that system-wide costs are not constrained, the system-wide measure of hospital inflation remains inflated, driving up Medicare costs beyond what they would be if there were system-wide constraints on hospital costs. Finally, the DRG payment system does not address other factors which contribute significantly to hospital costs such as increased utilization.

Government has encouraged the growth of the third-party reimbursement through its tax laws. Both employer and employee health insurance premium payments are excluded from taxable income. Revenue lost to the U.S. Treasury as a result of this exclusion totaled approximately $21 billion in FY 1984, as large as federal Medicaid outlays. In addition to this health insurance subsidy, Blue Cross/Blue Shield plans have been tax-exempt in most states.

Government subsidies to increase the supply of medical services have also influenced the rate of growth in health spending. Hospital expansion has been stimulated by the Hill-Burton program, the tax exemption of hospital construction bonds, and the generally liberalized business depreciation schedules contained in the 1981 Economic Recovery Tax Act. Construction expenditures for medical facilities which totaled $7.5 billion in 1981 are expected to reach $11.5 billion in 1985 and $17 billion in 1990. The supply of health professionals has been stimulated by billions of dollars in federal spending for health education and training.

Advances in medical technology have also created pressures which increase costs. New technology and high-cost therapies often require capital acquisitions which are in and of themselves costly. New technologies also require the addition of highly specialized personnel. In addition, hospitals in a single community often duplicate these high specialized and expensive services, leading to underutilization and inefficiency.

THE IMPACT OF RISING HEALTH CARE COSTS ON MEDICARE AND PRIVATE HEALTH INSURANCE

The most important health care program serving the elderly is Medicare. There is no doubt that the enactment of Medicare in 1965 has greatly increased the access of the elderly to health care. However, continued high rates of health care inflation threaten to defeat the access originally gained.

Because Medicare is patterned after the structure of the health care industry in general, rapid escalation in health care costs, particularly hospital costs, is driving up the costs of Medicare. Over the last five years, Medicare expenditures have increased at an average rate of 18% per year. In FY 1983, Medicare expenditures totaled $56.9 billion, up 12.7% since FY 1982.

With nearly three quarters of Medicare expenditures spent on hospital care (Chart 2), rising hospital costs, combined with other adverse economic circumstances, are taking their toll on the Hospital Insurance (HI) Trust Fund (Part A), the main social security trust fund financing Medicare. The HI Fund's Trustees project that the Fund's reserves will be exhausted by 1991 and that the fund will never regain solvency over the entire 25 year projection period. By 1995, the (HI)

Fund is projected to accumulate a $162.5 billion deficit. (This assumes that the rate of increase in DRG payments will remain at hospital market basket plus one percentage point after October 1, 1985 even though that amount of increase is only mandated by law through 1985. After October 1, 1985, the Secretary of Health and Human Services has the discretion to determine the yearly rate of increase in DRG payments.)

Although the crux of the Medicare shortfall is in the HI fund, expenditures are also rapidly rising in the Supplementary Medical Insurance (SMI) Fund (Part B). Since 1967, fiscal year expenditures for Part B have increased from less than $1 billion to more than $18 billion in 1983. Because three-fourths of federal outlays for Part B is financed by general revenues, it is not in danger of bankruptcy. However, the projected growth of SMI is significantly higher than the growth in general revenues. The Congressional Budget Office projects that general revenue contributions to SMI must increase about 17% per year to finance growth in the Part B program. To meet Part B's anticipated demand, CBO projects that the share of general revenues necessary to finance the SMI Trust Fund will increase its share of federal outlays from 3.1% to 5.7% between 1982 and 1988.

Rising health costs are a serious problem, not just for government health programs like Medicare, but also for the private sector. Since 1965, there has been significant growth in private expenditures for health insurance coverage. Growth in premium income of all private insuring organizations has been particularly rapid since 1975. In 1975, premiums paid for private health insurance totalled $36.9 billion. By 1982, this amount had grown to $100 billion, a 179% increase in just seven years. Most of these expenditures represent employer-paid health insurance premiums. The rising costs of this coverage can lower wages for workers, and/or cause higher prices for goods and services. For example, Chrysler recently estimated that its $373 million annual health insurance bill for its workers is adding $600 to the price of every car it manufactures.

Anxious to reduce the rate of increase in spending for Medicare, Congress and the Administration have drastically cut Medicare expenditures over the past three fiscal years, cutting $35 billion through FY 1987. This incremental approach to Medicare through the introduction of higher premiums, deductibles and similar measures that merely shift costs to beneficiaries does not address the underlying problems in the program and therefore has little impact on the escalation of costs in Medicare or in the health care sector. It should be clearly understood that extraordinary inflation in the health care delivery system is the root cause of Medicare financial difficulties, not vice versa. Financial remedies that are specific to Medicare will not and cannot solve Medicare's problems over the long run, nor contribute to a healthier delivery system in general.

The most important step in moderating Medicare and total health expenditures is to control the rate of growth in hospital costs. Without stable hospital costs:

National health expenditures will continue to escalate beyond reason;

The HI Trust Fund will continue to deteriorate;

Employers will be required to pay higher health insurance premiums which will, in time, be passed backward onto workers in the form of lower wage gains or passed forward to consumers in the form of higher prices for goods and services; and

All health care consumers, including the elderly, will pay higher out-of-pocket costs for health care.

THE ELDERLY ARE THE MOST COST CONSCIOUS HEALTH CARE CONSUMERS IN THIS COUNTRY

Most of the current proposals to reduce spending in Medicare are based on the notion that the elderly are not health cost conscious—that they are somehow insulated by Medicare from the "true" cost of health care. Because of this insulation, so the theory goes, the elderly misuse or overuse the system and thereby increase Medicare costs. AARP rejects this theory.

The elderly are the most cost conscious health care consumers in this country. They have to be. Medicare's contribution, as a percentage of the total health care expenditures of the elderly, only equals about 45%. The sad reality is: the higher the cost of Medicare, the less beneficiaries are getting from it.

Out-of-pocket payments borne by aged Medicare beneficiaries have outpaced the growth in elderly incomes. As a result, the elderly have been spending an increasing share of their mean per capita income in order to meet their health needs. Persons aged 65 and over paid roughly $700 out-of-pocket per capita for medical expenses in 1977. By 1984, according to conservative estimates, this amount is expected to increase by over 120% to $1550 per capita, equalling 15% of the annual mean per

capita income of the aged ($10,615), the same percentage as the elderly paid for health care before Medicare was fully implemented. This deterioration in Medicare's protection is expected to continue. By the year 2000, assuming no further cutbacks in Medicare are enacted, almost 20% of elderly per capita income is projected to be consumed by health care expenditures (Chart 3).

BENEFICIARY OUT-OF-POCKET COSTS

Personal liability for the cost of health care provided to the elderly derives from a number of sources, all of which have been subject to significant increases over the past several years. The elderly pay directly for the following:

1. Deductibles under Parts A and B.—The Part A deductible has increased from $104.00 in 1976 to $356.00 in 1984, an increase of 242% over the past eight years. The annual Part B deductible has increased from $60.00 in 1980 to $75.00 in 1983, an increase of 25%.

2. Coinsurance (Part B).—Actual per capita coinsurance charges borne personally by the elderly increased by 345% between 1972 and 1982.

3. Cost-sharing (Parts A and B).—In 1981, out-of-pocket payments for deductible and coinsurance liability associated with both parts of Medicare totalled $5.6 billion, a 166% increase in such out-of-pocket payments since 1976.

4. Charge reductions on unassigned claims (i.e., the difference between the Medicare "allowed" charge and the actual charge by the physician for which the beneficiary is personally liable).—Between 1977 and 1982, the total dollar amount of "charge reductions" passed on to elderly Medicare beneficiaries jumped from $674 million to $2 billion, an increase of 198% over a five-year period. Approximately 46 percent of all Part B claims submitted to Medicare for reimbursement at this time are "unassigned," compared to an over-50% non assignment rate in 1977. Nevertheless, beneficiary liability for "unassigned" claims has increased dramatically over the past five years even though the number of claims paid on assignment has increased during the same period.

5. Non-covered services.—Aged Medicare beneficiaries are personally liable for a significant number of critical non-covered services and products—including dental services, dentures, prescription drugs, eye glasses, hearing aids, etc.—for which they paid about $7 billion out-of-pocket in 1981, a 79% increase in their out-of-pocket liability for such products and services since 1977.

6. Coinsurance for Skilled nursing home care and charges for all ICF care.—Approximately half of all nursing home expenditures made on on behalf of the aged in 1981 were financed directly by out-of-pocket payments. As HCFA researchers have noted: "Even if other sources comprised half of the total payments, the average out-of-pocket expenditure for private-paying patients would still be over $100 per week."

7. SMI (Part B) premiums.—Out-of-pocket premium payments by the elderly for Medicare Part B coverage totalled $86.40 annually in 1977 as compared with a current annual figure of $177.20, a 103% increase in SMI premium payments by the elderly over the past seven years.

8. Private Health Insurance Premiums.—Approximately two-thirds of aged Medicare beneficiaries are sufficiently concerned about the gaps in Medicare coverage to purchase private health insurance policies designed to supplement medical expenses. Currently, low option private insurance plans cost aged Medicare beneficiaries approximately $230 per year, while high option plans can exceed $800 per year. These figures compare with an annual private insurance premium rate of $90 just five years ago. Finally, there is evidence to suggest that fewer and fewer of the elderly are financially able to retain such supplemental policies once they are purchased. Blue Cross/Blue Shield of Florida has recently pointed out that the "persistency rate" (i.e., the percentage of those aged beneficiaries who had coverage at the beginning of the year and continue to have coverage at the end of the year) has dropped from 93.3% in 1978 to 86.9% in 1982.

A NATIONAL COST CONTAINMENT STRATEGY

AARP advocates a system-wide approach to restrain the rate of increase in total health care spending. Cost containment proposals limited solely to Medicare (e.g., benefit reductions or changes in Medicare's reimbursement method, such as the newly enacted DRG payment system) encourage providers to shift costs to non-Medicare, private pay patients and therefore do little to reduce the overall rate of increase in hospital and health care costs. Such "solutions" accept the rapid increases in hospital and health care costs as a given and merely shift the cost burden among payors. Channeling ever more resources into a cost-inflated system, either by requir-

ing Medicare beneficiaries to pay more or by adding more revenue raised through taxes, will not solve the problem of rapidly rising health care costs.

In the short term, AARP recommends that the rate of increase in hospital expenditures be limited to a fixed percentage that is reasonably in line with the general inflation rate. The limit once established should apply to all third party payments to hospitals. Six states (Massachusetts, Connecticut, New York, New Jersey, Maryland and Washington) have had some measure of success in limiting hospital cost escalation by utilizing mandatory prospective budgeting and/or rate review programs. As a result, increases in hospital costs in these six states have consistently averaged three to four percentage points less each year than in other states. In 1982, the mandatory review states limited increases in hospital costs to 10.8%, while all other states experienced hospital cost increases of 16.3% (Chart 4).

The experience in these six states demonstrates that hospital costs can be significantly restrained by regulatory action. The Association supports the enactment of federal legislation that would encourage or force the states to establish mandatory hospital rate review commissions to assure that increases in payments to hospitals do not exceed the national limit and also to control the growth and expansion of hospital facilities.

As for physicians, they have steadily increased their fees at rates in excess of the general rate of inflation for years, thus demonstrating an ability to maintain targeted income levels. Physicians, like hospitals, must begin to share more of the financial risk created by modern, high technology medicine. Thus, policy makers must seriously consider a prospective pricing approach to physician payments. AARP is not committed at this time to any particular method of establishing a prospective payment system for physicians. We support timely enactment of the concept with actual implementation occurring after adequate consideration of the appropriate prospective payment methodology.

In addition to controlling hospital and physician expenditures, AARP believes that limits must be established to control excessive growth of medical facilities and health professionals. To help remove the economic incentives which have caused explosive growth in the supply of medical services, the Association recommends the following steps:

1. Limit tax breaks that promote the excessive expansion of conventional medical facilities, particularly hospitals, such as over-generous depreciation deductions when hospitals/nursing homes are sold;
2. Change tax laws to cause employers and private third-party payors to resist health provider cost escalation;
3. Make health/medical insurance corporations subject to the antitrust laws by repealing any state or federal antitrust exemptions; and
4. Subsidize the training of only those health professionals who agree to work in medically underserved areas, and provide incentive grants to health profession schools to encourage training and curriculum development in geriatrics.

Over the long run, AARP believes that regulation should gradually give way to the development of more market-oriented health care delivery systems. Health care delivery should be restructured to expand the supply of needed services that represent less costly alternatives to hospitals and nursing homes. Competing forms of care delivery such as health maintenance and preferred provider organization (HMOs and PPOs), small clinics, and ambulatory health care facilities of all kinds should be encouraged to the extent possible. Greater use should also be made of paramedical personnel (for example, geriatric nurse practitioners and physician assistants) especially in underserved rural and inner-city areas, and in such neglected institutional settings as nursing homes.

The major policy proposals to reform the health care delivery system are discussed below:

RECOMMENDATIONS OF THE 1982 ADVISORY COUNCIL ON SOCIAL SECURITY

During the 15 months of Council deliberations, AARP continually urged the Council to view Medicare as a part of the broader health care system and to address the forces driving the exorbitant rates of increase in hospital and health care costs. Unfortunately, the Council chose to limit its recommendations within the confines of the current Medicare structure by proposing additional sources of Medicare revenues and changes in Medicare benefits. In essence, the recommendations merely changed who pays for what; they do nothing to stem the forces driving the rapid increases in Medicare expenditures.

Overall, AARP opposes the Council's recommendations for restoring financial stability in the Medicare program. Not only do the recommendations fail to adequately

address the rapid escalation in health care costs, they also lack any semblance of balancing the legitimate interests of taxpayers, consumers, the elderly, and health providers. Most of the projected HI trust fund deficit is resolved by increasing taxes on consumers and asking beneficiaries to pay more out-of-pocket for health care. A summary of the Council's final recommendations and AARP's analysis follows.

Age of eligibility.—The Council recommends increasing the age of eligibility for Medicare from age 65 to age 67 by increasing the age three months per year from January 1985 to January 1989, and six months per year beginning on January 1, 1989. Full implementation would occur on January 1, 1990. After 1991, the age of eligibility would be periodically adjusted upward to reflect increases in life expectancy. Estimated savings through 1995: $74 billion.

AARP believes that age 65 should be retained as the age of eligibility for Medicare. Little data exists on how much today's pre-age 65 retirees pay for health insurance. However, it is estimated that the cost of health insurance for this group would be at least $3,400 per person per year (the current cost of buying Medicare coverage—$2,500 per year, plus the cost of marketing such a policy, estimated to be a minimum of $900 per year). Premiums of this magnitude would make health insurance coverage unaffordable for increasing numbers of older persons. In fact, a $3,400 premium in 1984 would cost an elderly consumer roughly 30% of the $10,615 estimated per capital income for that year. This premium would be in addition to the $1,550 beneficiaries currently (1984) pay out-of-pocket for required Medicare copayments and services not covered by Medicare.

Revised Part A benefits and increased Part B premium.—For Part A, the Council recommends that the benefit package be revised to: (1) provide an unlimited number of hospital days in a calendar year; (2) establish a coinsurance amount for each hospital day equal to 3% of the Part A deductible; (3) establish a coinsurance amount for the 21st—100th skilled nursing facility (SNF) day equal to 12.5% of the Part A deductible; and (4) limit the Part A deductible to two per year. (Currently, Part A covers 90 hospital days in each "spell of illness" with the beneficiary paying an initial deductible [$350 in 1984] and no coinsurance until the 61st day of hospital care. Part A also covers 100 days of SNF care with beneficiary coinsurance of 12.5% of the Part A deductible for the 21st to 100th day of care.)

Under the Council's plan, the Part B premium would increase from $199.20 to $297.20 in 1985 (a $98 increase) and rise thereafter. This increased premium would: (1) finance the cost of the 3% hospital and 12.5% SNF coinsurance described above; and (2) raise revenues for the HI trust fund. Estimated savings through 1995: $40 billion.

AARP believes that this proposal is merely an increase in already burdensome beneficiary out-of-pocket payments for health care. The benefit of unlimited hospital days in a calendar year is an improvement over current Part A benefits. However, since current law does not require daily coinsurance until the 61st day of a hospital stay, this proposal asks beneficiaries to pay for coverage that is currently provided at no charge. Moreover, asking beneficiaries to pay a surcharge to raise revenues for the HI trust fund does nothing to slow rapidly rising hospital costs, the main force driving Medicare expenditures.

The part B deductible.—The Council proposes that the Part B deductible be increased yearly according to the Consumer Price Index (CPI), an increase of roughly 6% per year. (Currently, the Part B deductible is $75 and is not scheduled to increase.) Estimated savings through 1995: unknown.

Increasing the Part B deductible once again represents another increase in beneficiaries' out-of-pocket costs. Furthermore, indexing the Part B deductible changes Part B, not Part A, and therefore does not address the financial difficulties of the HI Trust Fund.

Physician assignment.—Under the Council's plan, physicians would decide each year whether to always or never accept assignment for all Medicare patients. Physicians who decide to always accept assignment (participating physicians) would file an annual agreement with Medicare and have their names published in a directory for beneficiaries' use. Pariticipating physicians would also be offered streamlined billing and payment procedures. All claims of beneficiaries who receive services from non-participating physicians would be unassigned. Estimated savings through 1995: None.

Currently, only 54% of Medicare claims are assigned. Charges associated with unassigned claims are the second largest component of out-of-pocket payments made by beneficiaries for physician services. Although AARP supports incentives to encourage physicians to accept assignment, AARP fears that the Council's assignment proposal runs a serious risk of actually decreasing the already low assignment rate and thus add even more to beneficiaries' out-of-pocket costs. A 1983 HCFA study

found that the overall assignment rate would fall by at least 10% if an "always or never" system similar to the Council's recommendations were put into place.

Payroll taxes.—No further increases in payroll taxes above current law were recommended by the Council.

AARP agrees that payroll taxes should not be increased. Because payroll taxes are levied on a flat rate basis, payroll tax increases bear down most heavily on low-income workers. A recent Social Security Administration study has concluded that over half of all family units now pay more in social security taxes than they do in income taxes. Most economists agree that payroll tax increases also contribute to inflation and unemployment. Inflation can be exacerbated if employers attempt to pass on increased labor and production costs to consumers in the form of higher prices. Employment levels are dampened because the cost of hiring and/or retaining workers increases. The effect is especially severe in the case of marginal workers—workers with no skills or only limited skills—among whom unemployment rates are already the highest.

Alcohol and tobacco taxes.—The Council recommends increasing federal alcohol and tobacco taxes and earmarking the generated revenue for the HI trust fund. The Council did not specify the amount to be raised and earmarked, but suggested that Congress could raise as much as $100 billion through 1995 if necessary to keep Medicare solvent.

AARP opposes generating new sources of revenue for the HI trust fund until increases in health care costs, particularly hospital costs, are brought under control. Moreover, increasing federal alcohol and tobacco taxes would constitute an encroachment upon tax revenues heretofore left to the states.

Employer provided health insurance.—The Council recommends that any employer's contribution to an employee's health benefit plan exceeding $70 per month for an individual and $175 per month for a family be considered as income to the employee and subject to Federal, State, and local taxation in the same manner as wages. Earmarking an appropriate portion of these tax revenues to the HI trust fund should be considered. Estimated revenue through 1995: $7.1 billion.

AARP recognizes that potential exists in the tax code to create cost-containing pressure on employees and the private third-party insurance system. However, AARP believes that simply placing a flat cap on the tax-free allowance for employer paid health insurance premiums is a crude mechanism that fails to recognize the complexity of the incentives in the health care sector. Employer-paid health insurance premiums rise in response to the rising cost of health care. If health costs are not controlled and if this "tax cap" does not keep pace with the rise in health insurance premiums, health insurance benefits for workers and their dependents could rapidly erode.

Further, CBO reports that premiums of group health insurance plans are not indicative of the level of benefits within the plans. Factors such as the size of the group, the averge age of its members, and local medical prices and style of practice play major roles in determining group insurance premiums. Since premium rates are directly affected by any one or combination of these factors, a uniform ceiling would not necessarily target the incentive to reduce insurance coverage on those with the most comprehensive benefits. For example, a small employee group with a high average age in an area where medical prices are extremely high may have little chance of having premium rates that fall within the cap, even though the level of benefits may be modest.

Voluntary voucher.—Under the Council's plan, beneficiaries would have the option each year of receiving a fixed sum of credit to purchase private health insurance in lieu of Medicare coverage. Estimated savings through 1995: none; $50 million in program costs.

AARP believes that further study is needed before any voucher proposal can be considered a realistic alternative to current Medicare benefits. The Association is concerned that setting a voucher amount could eventually invite Congress to limit that amount as a means for achieving budgetary reductions. Moreover, several other significant problems exist. Little information currently exists on how to incorporate variations in health status in determining the voucher amount. Further, vouchers assume that the consumer is sufficiently informed about the available alternatives in the private health insurance market. The total lack of comprehensive provider specific information makes this proposal an illusion. A voucher concept can only be successful in an environment of full disclosure. The health care marketplace is shrouded in confidentiality. Until that changes, vouchers offer very little benefit to consumers.

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THE MEDICARE SOLVENCY AND HEALTH CARE FINANCING REFORM ACT OF 1984, SUMMARY OF THE "KENNEDY-GEPHARDT BILL"

The bill's purpose is to ensure the solvency of the Medicare program through reform of our health care financing system. AARP supports this approach because the larger system is the dog wagging the Medicare tail. This goal is accomplished by encouraging states to set up their own individually tailored health care cost containment programs.

States have the flexibility to set up rate setting, competitive or voluntary cost containment programs. All states must meet several basic requirements. One is that states must keep spending increases on hospital and physician inpatient hospital services within revenue limits set for each individual state. This test will require states to rein in excessive increases in hospital costs. It will have the additional benefit of requiring states to put physicians in the position of having to seriously consider spending on health care. This step is essential because physicians direct 70 to 80% of patient care.

In addition, all state programs must set up a mechanism for providing funds to those hospitals that bear an excessive burden of charity care and bad debt. This requirement will help those hospitals that have such a burden to remain financially sound.

A third major requirement of all types of state programs is that revenue from competitive health plans must be exempt from calculation of state revenue limits. The effect of this provision will be to encourage long term, competitive reform in the health care delivery system. Hospitals and physicians will have the incentive to serve people from competitive health plans because revenue from these patients would not be subject to limitation. Encouragement of competition is beneficial in that competitive health plans have potential for substantial cost savings.

There are additional requirements for each type of state cost containment program. Rate-setting programs must treat all payers for health care services equitably. This step prevents hospitals and physicians from shifting costs from one payer to another and thus evading revenue limits. Competitive programs must encourage new forms of health care delivery systems and must also provide for consumer information about competitive health plans. Voluntary programs have no requirements other than those applying to all state programs.

There are various incentives for states to set up their own programs. A major incentive is that any state implementing a program will get a yearly percentage increase in Medicaid funding from the federal government. In addition, states that set up their own program have looser revenue limits than do those states that force the federal government to set up a program for them.

If a state decides not to set up its own cost containment program or exceeds its revenue limits over a five year time period, then the federal government will set up a rate-setting program for the state. The federal program will be phased in over two years, allowing states time to adjust to it.

During the first year of the phase-in period, private payers for health care services (e.g., private insurers) will be brought in under a prospective payment system, similar to the one set up for Medicare. In the second year, this system will be expanded to include payment for physician inpatient hospital services.

The federal government must have a back-up cost containment program for those states that refuse to limit the rate of increase in spending on hospital services. It is essential to have such a program because unless something is done to limit spending on hospital and physician services Medicare will soon become bankrupt and will run up trust fund deficits. Equally important is the effect excessive spending has on other consumers. Premiums for health insurance are constantly rising and employers are being forced to cut back on insurance protection for their workers. People of all ages have a stake in containing health care costs, and the Kennedy-Gephardt bill can accomplish this goal.

AARP strongly supports the structural approach to health care cost containment proposed in HR 4870. Providing incentives for states to develop their own cost containment program is appealing because it puts the responsibility at the level of government most familiar with the local health care cost environment. H.R. 4870 is very complicated; it addresses a complicated problem. Like any other legislative proposal, AARP would seek amendments to improve the bill as it works its way through the legislative process.

THE MEDICARE INCENTIVES REFORM ACT (MIRA)

Senator John Heinz has introduced legislation giving states a financial incentive to control their own health costs. The Medicare Incentives Reform Act (MIRA), S.

2752, has three primary goals: to restore solvency to the HI Trust Fund, hold down health care costs for all Americans and to improve health benefits for the elderly. The bill has two major components: (1) A Medicare-specific component that would revise the Medicare coverage for inpatient services, place volume limits on hospital discharges by DRG, require mandatory assignment for physicians, provide limits on patient costs, and change beneficiary cost sharing; and (2) encourage states to establish their own Health Care Efficiency Programs.

The Heinz bill provides clear incentives for the adoption of state-wide approaches to hospital and physician payment reform. It is similar to H.R. 4870 in that it encourages state level solutions. It differs, however, in several important respects, including: requirements for state program compliance; its method for capital and physician payments; its inclusion of catastrophic hospital coverage, and its effect on the out-of-pocket expenses of Medicare beneficiaries.

In Kennedy-Gephardt, states are given two years to start their own health care cost control plans that include all payers. States that do not start their own programs within two years would automatically be covered by a federal plan. The Heinz bill would provide financial incentives for states to administer their own regulations. To that end, MIRA would tighten federal payment limits to hospitals (under the existing prospective payment system) in those states that do not set up their own cost control plans.

Kennedy-Gephardt would incorporate payment of inpatient doctor services in the hospital prospective payment system. MIRA would create a separate fee schedule for doctor costs that encourages primary and preventive care and discourages unnecessary hospitalization and hi-tech procedures. Moreover, MIRA would require doctors to accept Medicare rates as full payment for inpatient services and would include financial incentives for doctors to accept Medicare as full payment for outpatient services.

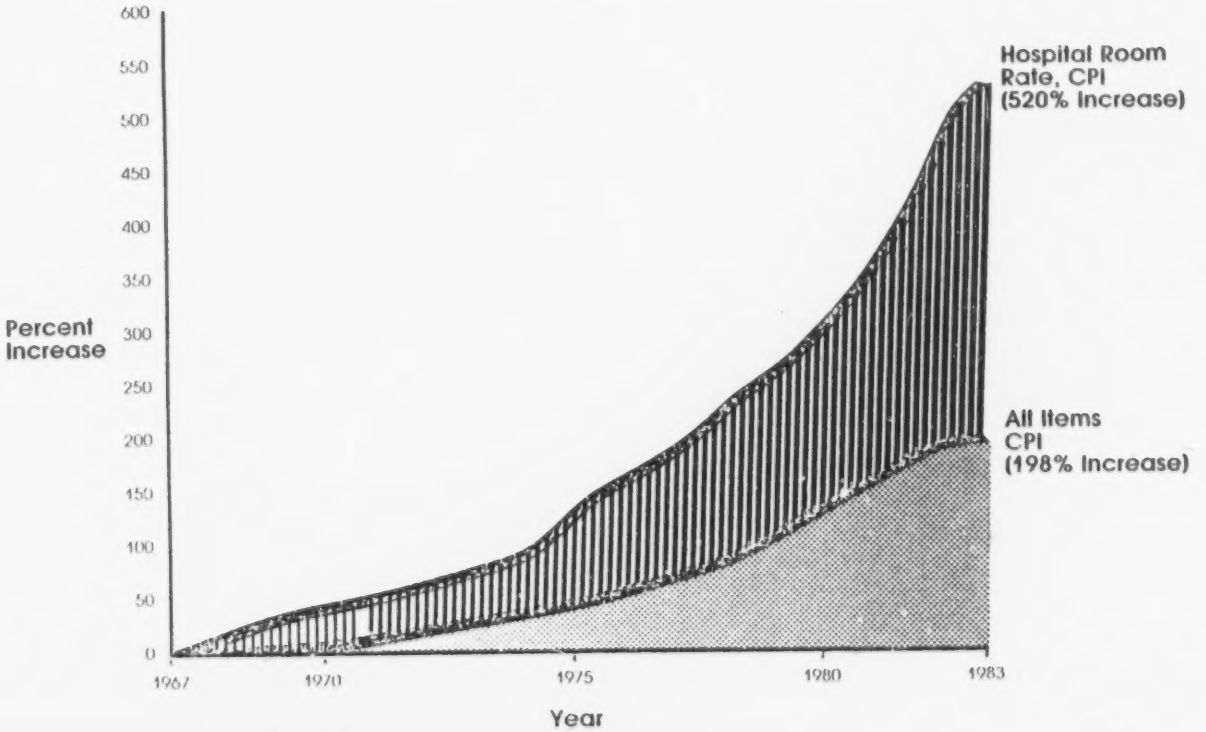
AARP's objections to MIRA pertain to its inadequate authority to get the states to develop their own Health Care Efficiency Programs. While major changes are made in the Medicare program. MIRA's incentives encouraging state plans are not compelling. AARP fears that without tough state cost containment plans the forces driving Medicare costs up will not be restrained, costs will continue to escalate and the Medicare benefit will erode even further. AARP believes that the carrot must be backed up by a residual federal stick if states do not take action. We look forward, however, to seeking amendments in MIRA as it works its way through the legislative process.

CONCLUSION

Health care cost containment is the most important domestic policy issue facing this nation. An across-the-board approach that limits the rate of increase in both hospital and physician expenditures for all third-party payers is required to slow costs and ensure a stable, affordable health care delivery system. Both Kennedy-Gephardt and MIRA acknowledge the need for system-wide reform but only Kennedy-Gephardt provides sufficient legislative authority to mandate system-wide reform. AARP strongly believes that the best interests of all health care consumers, both young and old alike, are best secured from slowing health care cost escalation throughout the system and not just through Medicare alone.

CHART 1

SOARING HOSPITAL COSTS

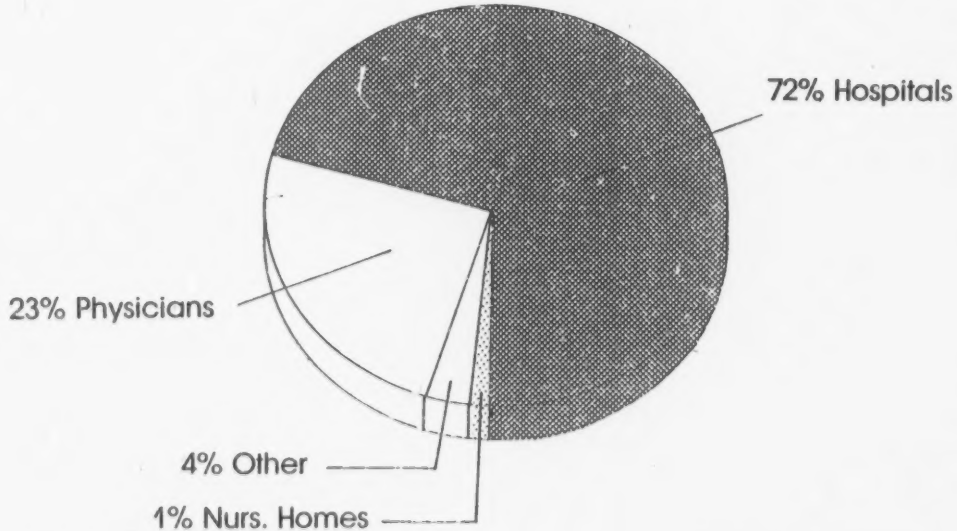


Source: U.S. Bureau of Labor Statistics

CHART 2

How the Medicare Dollar Is Spent

1982 Total Medicare Expenditures:
$50.5 Billion



Source: Health Care Financing Administration

CHART 3

ANNUAL HEALTH CARE PAYMENTS MADE BY THE AGED

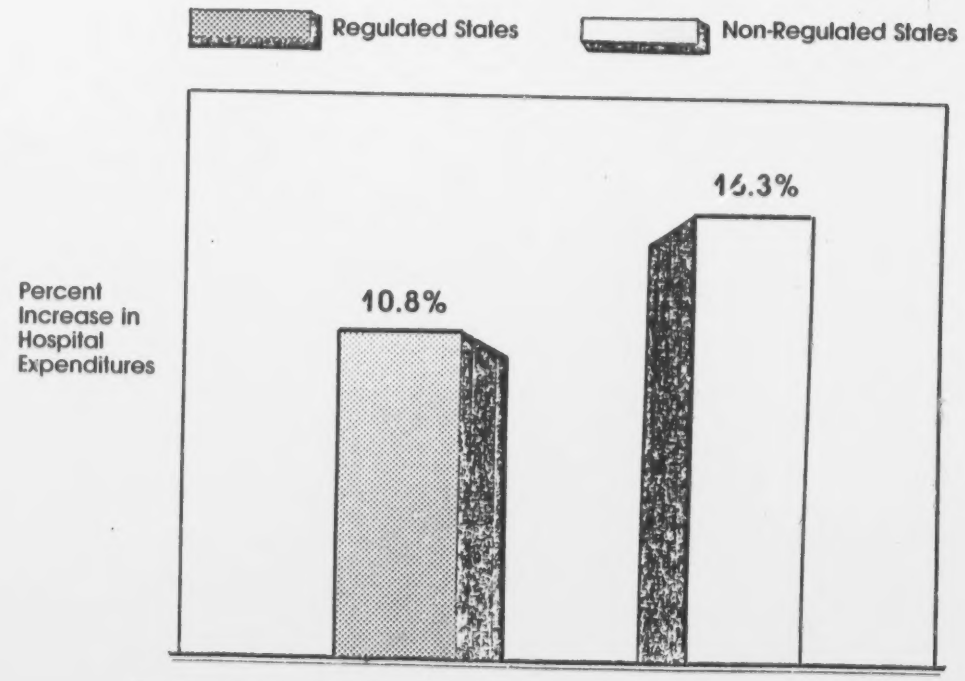
	Per Aged Person	Payments as a Percent of Income
1966 (Pre-Medicare)	$300	15%
1977	$698	12%
1981	$1198	14%
1984	$1550	15%
1989	$2208	16%
1993	$2892	17%
2000	$4637	19%

Source: Health Care Financing Administration, American Association of Retired Persons

CHART 4

HOSPITAL EXPENDITURES UNDER MANDATORY RATE REVIEW SYSTEMS

(1982 — 1983)



Source: American Hospital Association

Chairman JACOBS. We thank the panel for its contribution.

Mr. Duncan?

Mr. DUNCAN. I have no questions, Mr. Chairman. Thank you.

Chairman JACOBS. Does any of you have a comment on Mr. Roosevelt's proposal for the shift in the bureaucracy of the program?

Mr. GLASSER. Very briefly, and I have not seen details. But to the extent this is talking for a separate administration for the Social Security Programs, most of us are—most of those in our coalition are favorably inclined toward it. We find that the Social Security and Medicare Programs, when subsumed in the present budget are being manipulated to an extent that it is unfortunate, both in terms of those contributing and those who are receiving benefits.

Mr. HUTTON. We would agree very much to separate the Social Security System from the—from being under the Presidential budget but we do not agree to separate these problems which are older people's problems, Medicare from Social Security.

Mr. HACKING. I would have to reserve comment until we have a chance to look at that proposal.

Chairman JACOBS. Thank you. The committee expresses its gratitude to the panel for its contributions. I thank you. I express my personal apologies to Mr. Newman for having inadvertently passed over him and for the fact that I think I am going to do it advertently this time. Mr. Gephardt, who was scheduled to testify earlier, was in another part of the Capitol doing God's work there, and the good Lord has brought him to us at last.

STATEMENT OF HON. RICHARD A. GEPHARDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Mr. GEPHARDT. Thank you, Mr. Chairman, and members of the committee.

I deeply appreciate your willingness to have this hearing and to allow me to be here this morning. I have written testimony which I hope will be made part of the record, but I would like to shorten my presentation a bit, if that would be OK.

Chairman JACOBS. Well, OK. [Laughter.]

Mr. GEPHARDT. After that I can go to a few comments or questions, or whatever you would like to do at that point.

I feel these hearings are timely and very important because I believe that our financial problems in Medicare—although we have seen some marked improvement and that certainly is welcome—it is my belief that the deficits or potential insolvency of the trust funds are still with us and are not problems that have gone away.

I think that the message from the Secretary of Health and Human Services that we have made or declared victory over medical inflation and claiming that it is now under control and that we need not worry is really the wrong message. I think there may be a lull, but the storm is not over.

I believe that we need to analyze why our medical costs are increasing so fast as part of trying to address the problem. I believe they increase for a complex set of reasons ranging from an aging population to new technology that allows us to do such things as heart transplants and other procedures that we couldn't do even a few years ago. Rising malpractice premiums, increasing the tenden-

cy for physicians to practice defensive medicine, and general inflation also cause the cost of care to increase.

All of these factors contribute to rising health care costs, but I believe there is one reason that we can do something about, and that is the economic structure of the health care system.

The health sector of our economy is not driven by normal economic incentives. As a matter of fact, some economists say the health sector has severe economic problems. Because of insurance, many consumers are not informed and are not sensitive to the cost of care and providers are not offering products that consumers can understand and compare the purchase of. While those are clearly generalizations, they describe many of the providers and consumers in the market.

You have heard from my colleague and yours, Senator Ted Kennedy. As you know, with him, we have written the Reform Act to address precisely the economic deficiencies in the health care system. We feel it was important to prove that we can save a substantial amount of money in health programs through structural changes rather than raising taxes or cutting benefits. We felt it important to recognize that employers face similar cost problems to the Federal Government and that we cannot simply shift the burden to their shoulders. We also felt that it was important to realize that the elderly and other consumers need meaningful choices when purchasing health plans. We felt that it was important to end the controversy between regulation and competition in health policy and recognize that we need to use both to get the job done.

The proposal promotes, as you know, systemwide reform in the health system on the State level. The States are encouraged to devise their own plans based either on a competitive strategy or regulatory strategy to moderate medical costs. That allows the States a lot of flexibility to meet individual needs. However, they must meet the goals of moderating health costs as specified in the proposal.

We do not propose a set of rigid rules and regulations that a State must meet, instead they must follow broad guidelines and meet a financial goal of moderating costs. Importantly, States are given 5 years to meet the goals. If they fail, the Federal residual program goes into effect. That program extends the current Medicare prospective payment system to cover all patients. The Federal residual program is necessary to ensure that we succeed in moderating the cost of health care.

Importantly, the proposal also includes a number of provisions to increase competition. A State can choose to meet the guidelines through a competitive strategy. If regulations are implemented, however, health maintenance organizations and competitive medical plans are able to negotiate independently with hospitals and physicians without being concerned about either State or Federal regulations.

On the demand side, large employers are required to offer as many as six federally qualified HMO's to their employees and in addition, employers are required to offer an equal contribution to the various competitive medical plans offered and the insurance option.

In Medicare, we propose including the physician payment in the prospective payment system. We believe physicians are in charge of the medical system, they decide who goes to the hospital and whether a patient needs a lab test or an x ray. We must encourage and reward physicians for practicing efficient methods if we are to succeed.

In conclusion, let me say that in our proposal there is obviously room for modification and improvement. Many of the issues we faced were very difficult issues and ones which we answered but in all cases did not feel entirely satisfactory with the answer we came up with.

I guess I am saying that we look forward to engaging in communication with this subcommittee and the entire committee about this issue in the days to come. Our product is not perfect, it is a first step at trying to address this whole question in a new and different way. We look forward to engaging in that communication and working with the subcommittee in trying to come up with some sensible answers in this extremely important area.

I would end by saying that next year we face the deficit problem. If the deficit problem is to be surmounted, we have to deal with Medicare. There is simply no way to get around it. If we deal with Medicare, we have three simple choices: raise taxes, cut benefits, or make the system work better. I clearly prefer the third and I think the sooner we begin focusing on that, the sooner we can try to put something into legislation that will move us further toward that goal.

Thank you very much.

[The prepared statement follows:]

STATEMENT OF HON. RICHARD A. GEPHARDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

I applaud Chairman Andy Jacobs of the Ways and Means Health Subcommittee for holding these timely hearings on Medicare. Medicare's financial problem—whether you view it as contributing to the deficits or as causing the insolvency of the trust funds—is still with us.

Over the past few weeks, however, the Secretary of Health and Human Services has declared victory over medical inflation, claiming that is it now under control. The message from the Administration: is don't worry—medical inflation has moderated and Medicare will be okay.

I disagree. There may be a lull in rising health care costs, but the storm is not over.

The mid-year estimates from CBO indicate that Medicare will cost $64 billion in 1984. By 1989, it will rise to over $115 billion. That's an increase of eighty percent.

Secretary Heckler was talking about medical inflation and it may be better than the first two years of the Reagan Administration, but the ratio of medical inflation to general inflation is not lower than it was in the 1960s or the 1970s.

The facts indicate that while the cost of Medicare is not going up as much as anticipated, it is still going up too fast, adding to the federal debt and straining the trust funds.

Why are medical costs increasing so fast? They increase for a variety of complex reasons ranging from an aging population to new technology that allows us to do heart transplants. Rising malpractice premiums increase the tendency for physicians to practice defensive medicine. General inflation causes the cost of supplies to increase. All of these factors contribute to rising health care costs, but there is one thing I believe that we can do something about—the economic structure of the health system.

The health sector of our economy is not driven by normal economic incentives. As a matter of fact, some economists say that the health sector has severe economic problems. Because of insurance many consumers are not informed and are not sen-

sitive to the cost of care. Providers are not offering products that consumers can understand, compare and purchase. While those are clearly generalizations, they describe many of the consumers and providers in the market.

My respected colleague from the Senate, Senator Ted Kennedy and I wrote the "Medicare Solvency and Health Care Financing Reform Act" to address the economic deficiencies in the health system and to solve the financial crisis facing the Medicare trust funds.

We felt that it was important to prove that we can save a substantial amount of money in health programs through structural changes. We felt that it was important to recognize that employers face similar cost problems to the federal government and that we can't simply shift the burden to their shoulders. We felt that it was important to realize that the elderly and other consumers need meaningful choices when purchasing health plans. We felt that it was important to end the controversy between regulation and competition in health policy and recognize that we need to use both to get the job done.

The proposal promotes system-wide reform of the health system on a state level. The states are encouraged to devise their own health plans based either on a competitive strategy or a regulatory strategy to moderate medical costs. This allows the states a lot of flexibility to meet their individual needs. However, they must meet the goals of moderating health costs as specified in the proposal. We do not propose a set of rigid rules and regulations that a state must meet. Instead, they must follow some broad guidelines and meet a financial goal of moderating health costs.

States have five years to meet those goals. If they fail, a federal residual program will go into effect. That program extends the current Medicare prospective payment system to cover all patients. The federal residual program is necessary to insure that we succeed in moderating the cost of health care.

The proposal also includes a number of provisions to increase competition. A state can choose to meet the guidelines through a competitive strategy. If regulations are implemented, however, health maintenance organizations (HMO) and competitive medical plans (CMP) are able to negotiate independently with hospitals and physicians.

On the demand side, large employers are required to offer as many as six federally qualified HMOs to their employees. In addition, employers are required to offer an equal contribution to the various competitive medical plans offered and the insurance option.

In Medicare, we propose including the physician payment in the prospective payment system. Physicians are in charge of the health system. They decide who goes to the hospital and whether a patient needs a lab test or an x-ray. We must encourage and reward physicians for practicing efficient medicine, if we are to succeed.

While the proposal is not technically perfect, and I solicit suggestions to improve it, I believe that it provides the broad outline of where national health policy must move. We provide a strategy to moderate health care costs. The Congressional Budget Office has estimated that the proposal saves the federal government $18 billion over five years. The proposal does this without crushing innovation, without cutting Medicare benefits and without raising taxes. We encourage competition but recognize the need for regulation.

Senator Kennedy and I come from very different perspectives, but we agree on this proposal. The health sector needs comprehensive and immediate attention. Costs continue to rise, the longer we delay.

Chairman JACOBS. Thank you, Dick.

Mr. Duncan?

Mr. DUNCAN. I would like to thank our colleague for I think one of the best presentations on this subject that I have heard in a long, long time, and I commend you for doing it. It certainly gives us something to work with and, as you say, you are not wedded to every section of it, but it is something we can all get together and work something out on.

Thank you, again, Dick.

Mr. GEPHARDT. Thank you.

Chairman JACOBS. I echo those compliments to our colleague from the gentleman from Tennessee and observe that very few members of Congress bring to us such scholarly and well-researched proposals, and Mr. Gephardt didn't start this year, you

have had a record in the Congress which really is the envy of all of us for your imaginative proposals, and they are getting better.

Mr. GEPHARDT. Thank you, Mr. Chairman. I appreciate the opportunity to be here.

Chairman JACOBS. Now, at long last our omitted witness, Mr. Newman, again with my apologies for overlooking you, sir. I predict that history will not overlook you.

STATEMENT OF HOWARD NEWMAN, WASHINGTON, DC, FORMER ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. NEWMAN. Mr. Chairman, since my prepared testimony echos much of what has already been presented by previous speakers, I would like to submit that testimony for the record and limit myself to a few brief remarks.

Congressman Gephardt just said the health care system is not driven by normal economic incentives. I agree with that statement. Your staff, on the other hand, has told me that you have been known to offer a financial incentive for brevity, and so I would like to behave like a rational economic man this morning and make only two comments.

There is a set of principles that seem to me to provide a reasonable base on which a health care financing system which is both fiscally prudent and fair can be established. To be effective, any plan must contain the overall costs of medical care, not simply shifting them from one level of government to another, from one sector of the economy to another, or from one class of institutions to another.

Recognizing the diversity of local needs and circumstances, States should be allowed to devote their own cost control programs under broad, but exacting, Federal guidelines. In order to invest resources most prudently, any program should foster innovation in the delivery of services, such as HMO's, hospice care and outpatient surgery which promote more efficient, effective and accessible care.

Finally, it goes without saying that any program must be implemented fairly, both as to providers, as well as beneficiaries. Cost controls must include all payers and any plan must not discriminate against health institutions serving large numbers of inadequately insured or uninsured individuals.

These principles could be met in a variety of ways, the Kennedy-Gephardt proposal being one example.

My other comment, Mr. Chairman, is reflective of my experience, a couple of tours of duty in the Federal Government in the latter stages of the Carter administration as the Health Care Financing Administrator and earlier as the Commissioner of the Medical Services Administration.

I would like to offer the committee a thought not expressed by others this morning, and that has to do with the fact that any health financing scheme for this country, any of those proposed or any of those currently in place involves huge expenditures of public funds. The public has a right to expect that those funds are well spent and that those programs are well managed.

That, in turn, requires effective people dedicated to careers in public service. My plea is that we put an end to the degradation of the civil servant, that we encourage the best and brightest among our young people to pursue such careers and that we recognize the significance of their effect on the millions of people whose lives are touched by these programs.

Thank you.

[The prepared statement follows:]

STATEMENT OF HOWARD NEWMAN, FORMER ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. Chairman and Members of the Committee, my name is Howard Newman. During the latter portion of the Carter Administration I served as Administrator of the Health Care Financing Administration. In the early 70's, for almost five years, I was the Commissioner of the Medical Services Administration in the Department of HEW. Between those two periods I served as the first President of the Dartmouth Hitchcock Medical Center in Hanover, New Hampshire. I now practice law in Washington, D.C. and am testifying before the Committee today as an individual, not in any representative capacity. I very much appreciate being invited to talk on this most important subject.

The Kennedy-Gephardt Bill we are discussing today is designed to solve the Medicare trust fund crisis and slow inflation in the entire health care system. The bill focuses on three areas to reform the health care system: a system-wide approach at the state level to moderate health care costs; expansion of the Medicare prospective payment system to physicians; and promotion of prepaid health plans to increase competition.

The fundamental principles underlying this legislation are sound. There are several important features of the approach embodied in this proposed legislation that distinguish it from recent Administration proposals: it offers a plan that focuses on all medical costs, not just those of federal programs; it attempts to deal with the problem of increased expenditures under public programs by controlling overall medical inflation rather than reducing benefits or program beneficiaries; and it sees controlling medical inflation not as an end in itself but as a means to assure access to needed quality care for all Americans.

In many ways, American medicine can be judged a success. Medical research has provided cures for diseases that had been uniformly fatal. Life expectancy has increased sharply in the last two decades. But now, American medical care is in trouble. Its costs are staggering and their continuing rapid increase threatens millions of Americans. The rapidly rising costs affect individuals, as out of pocket costs and health insurance premiums rise rapidly; employers, who pay over 80 percent of the cost of health insurance premiums; and, government at all levels, as Medicare, Medicaid, and local government expenditures rise rapidly.

The United States spent $322 billion on medical care in 1982—10.5% of our GNP. In 1983, medical expenditures increased another 12% while the general inflation rate was only 3.9%. Medical care costs have been consuming an ever larger portion of our nation's resources for many years. By all projections, these costs will continue to skyrocket without fundamental reform of the medical care system. Recent estimates indicate the nation's medical care bill will reach an extraordinary $690 billion in 1990—more than double the 1982 level—if present policies continue. Moreover, spending for health is a major contributor to the nation's current and projected budget deficits.

We now spend over $1 billion per day on medical care. Properly spent, that should be more than enough to pay for decent care for every American. Currently, however, our medical care services are neither equally available to all citizens nor efficiently produced. We need to restructure American medical care to reduce inequity and inefficiency, control costs for all payors and realize the long-held goal of making America's health care affordable and accessible to all. In 1965, the passage of Medicare symbolized that promise to the elderly and the poor. We should be committed to making access to affordable care a reality rather than the shaky promise it has become in the past four years.

The current administration sees these medical care problems only as ones of cost to the federal government, particularly due to rising Medicare and Medicaid expenditures. Their response has been to cut Medicare benefits, to increase cost sharing by the elderly in Medicare, to reduce Medicaid payments, and to cut Maternal

and Child Health and important primary medical care and preventive health programs. They pay providers less for Medicare and Medicaid patients, and, as a result, they are shifting the costs of public programs to workers covered by private health insurance and placing the elderly and poor at risk of receiving second rate care. Administration actions in the past four years have stressed reliance on competitive approaches and elimination of regulation to control health care costs:

Proposed taxing as income to employees employer contributions to health insurance plans above $175 per month. This would increase taxes of one-third of all workers by $4 billion in 1985. The measure was not accepted by the Congress in 1983.

Proposed elimination of all federal health planning legislation and funding although health planning has provided a means for curbing unnecessary capital investment in hospitals.

Opposition to all payor systems of prospective payment and adoption of limits on payments to hospitals for Medicare patients.

Opposition to effective curbs on physician fees that include mandatory assignment under Medicare.

Unwillingness to go beyond Congressionally enacted reform of Medicare payments to hospitals when this represents only a partial step to achieving cost restraint for all patients and may simply shift costs from the Medicare program to privately insured patients.

Much of the urgency now felt about controlling medical care costs comes from the impending insolvency of the Medicare trust fund. Despite its accomplishments in protecting the elderly, Medicare is now under seige. Its financing "crisis" results from hospital costs increases, which have outpaced increases in payroll tax revenues, and from the uncontrolled rise in physician charges. The Reagan administration's solution to this crisis has been to cut Medicare benefits. Medicare has already been cut to the point where average senior citizens spend the same percentage of their income on medical care as they did before the passage of Medicare in 1965. An approach that focuses on reducing benefits and eligible beneficiaries is based on the false assumption that the elderly, disabled and poor are excessive users of medical care. What we need is a program to control hospital and physician costs for all Americans. Without effective control of medical care costs for all Americans, no amount of reform will save Medicare.

Medicare was originally identified by the current administration as a "safety net" program to be exempt from federal budget cuts. That status was short-lived. Medicare expenditures have been reduced by disproportionately penalizing program beneficiaries rather than controlling the costs of their care. The Administration's legislative program is full of proposals to cut Medicare benefits and to increase the out-of-pocket costs of both the elderly and poor. Because it focuses on constraints only in these public programs, it results in a rapid shift in costs to workers covered by private health insurance. This does little to restrain health care cost inflation. And, many of these proposals have a direct adverse impact on the aged and disabled:

Increases in Medicare co-insurance and deductibles.—Medicare beneficiaries would not only pay the first day deductible for hospital care but also pay 8 percent of the cost of their hospital care between the 2nd and 15th day they are in the hospital and 5 percent of the cost between the 16th and 60th day of hospital care. For an aged couple with more than 60 days of hospital care in a given year, these requirements would mean out-of-pocket costs of $1,500 just for the hospital bill. Congress has refused to pass this provision.

Increases in Medicare deductibles for physician services.—The deductible for physicians' services was increased from $60 to $75 in 1981. The Administration also requested that this deductible be automatically increased every year, but Congress has refused to go along with this request.

Increase in the Medicare premium for physician services.—The premium for physician services would be increased from its current level of $175 to $366 by 1988. Democrats in the House have opposed this hike.

Delay in the date Medicare coverage begins.—Medicare coverage would be put off until the month after a senior citizen reaches age 65 instead of starting the same month. This is an example of exposing a few to catastrophe in the interests of rearranging the accounting for the illness costs that must be paid by someone.

Voluntary voucher program for Medicare beneficiaries.—Such a program would encourage elderly beneficiaries to leave the Medicare program and purchase private health insurance. By encouraging elderly persons in good health—the best health risks—to go to private insurance companies, it could lead to the eventual dismantlement of Medicare without achieving any economies, since private health insurance

for the ages has already been amply demonstrated to be more expensive than Medicare.

Opposition to improvements in Medicare benefits.—Such improvements include coverage of hospice in Medicare benefits—including the coverage of hospice services for the terminally ill (a measure passed by Congress despite Administration opposition), coverage of pneumococcal vaccine against pneumonia, and coverage of immunosuppressive drugs for organ transplants.

Temporary freeze on Medicare physician fees without mandatory assignment.—The Administration has failed to request legislation to require physicians to accept Medicare fees as full payment. Instead they have proposed freezing what Medicare would pay physicians, leaving the elderly to pay $3 billion annually for the extra fees physicians load on to the Medicare determined reasonable fee. In late June, the Congress, with bipartisan support, enacted an overall freeze on physician charges to the elderly and disabled in a way that will largely prevent the physicians from shifting their charges.

We have seen no plans from the Executive Branch to assure the financial solvency of Medicare through the remainder of this century. Instead they claim that the new system of paying hospitals on the basis of patient diagnosis under Medicare will be adequate to eliminate Medicare's problems. This is clearly not the case. The Medicare trustees, including three of Mr. Reagan's Cabinet officers, recently reported that even with this system, Medicare will be bankrupt by the early 1990s. The Congressional Budget Office has estimated that Medicare will accumulate a deficit of nearly $100 billion between now and 1995.

There is a set of principles that seem to me to provide a reasonable base on which a health care financing system which is both fiscally prudent and fair could be established. To be effective, any plan must contain the overall costs of medical care, not simply shift them from one level of government to another, from one sector of the economy to another, or from one class of institutions to another. Recognizing the diversity of local needs and circumstances, states should be allowed to develop their own cost control programs under broad but exacting federal guidelines. In order to invest resources most prudently, any program should foster innovation in the delivery of services (such as HMOs, hospice care and outpatient surgery) which promote more efficient, effective and accessible care. And, finally, it goes without saying that any program must be implemented fairly—both as to providers as well as to beneficiaries. Cost controls must include all payors, and any plan must not discriminate against health institutions serving large numbers of inadequately insured patients or individuals with insurance. These principles could be met in a variety of ways—the Kennedy-Gephardt proposal being one example.

Until recently, hospitals had been used to receiving a blank check—getting paid whatever they spend. This is just not possible any more. Now hospitals, like the rest of us, need to know in advance how much that they can expect to earn so that they can keep their spending within bounds. States should be encouraged to develop programs for establishing these bounds. Operating within nationally set spending limits, states will then have the opportunity to develop the rules for paying their own hospitals.

Congress recently took some important steps toward controlling costs with its reform of Medicare hospital reimbursement and temporary freeze of physician fees under Medicare. These are good first steps, but we need to go beyond them if medical care inflation is to be curbed.

We all know there is lots of waste in hospital care—tests that are not needed, days that are not needed, even care that is not needed. Health professionals and administrators have the ingenuity to get this waste in check—and with the right incentives they will be motivated to do so. But right now, all the incentives in the system encourage them to use their ingenuity to find out which patients have insurance and which do not; which are Medicare patients for which they will be well paid and which are not. Hospitals that treat a lot of very sick people or very poor people lose money; and patients who are very sick or uninsured go without care.

In order to stop this, you must put all payers—Medicare, Medicaid, and private insurers—on similar terms and pay hospitals for treating people who cannot pay for themselves. Then hospitals will do well by taking care of all sick people efficiently, not by choosing which sick patients to serve.

Any effective program to contain costs must look beyond hospitals. Health professionals, especially doctors, play a central role in determining what services are provided and how much we spend. Physicians, like hospitals, have had little reason to think about the costs of care they give. Many times, they get paid for the wrong thing—tests not time, procedures not care. That has to change. Physicians should not be able to seek more from their patients than fair levels of reimbursement pro-

vided by public or private payors. Physicians are entitled to fair, predictable payment for services rendered—no more, no less.

Decisions about the proper practice of medicine—within resource limits—properly rest with health care professionals and their patients. But public policy decisions about how much the nation spends on medical care should be informed by the continuing dialogue with health professionals and medical institutions, the health insurance industry, and other affected organizations and individuals. Throughout this process, we should also bear in mind that cost containment is not an end in itself. If we are able to bring medical care inflation under control, we can turn our attention to improving our present medical care programs and sensibly promoting our health.

Chairman JACOBS. Thank you, Mr. Newman, for your eloquent testimony.

Mr. Duncan?

Mr. DUNCAN. Thank you, Mr. Chairman. Thank you, Mr. Newman.

We usually keep the best for the middle or the last, so we appreciate your patience. I know you have been most helpful to us in your testimony.

Chairman JACOBS. I apologize again, and am happy to inform you that so far, you have won.

Mr. NEWMAN. Thank you, Mr. Chairman.

Chairman JACOBS. Our next panel consists of the American Hospital Association, Howard Berman, group vice president; American Medical Association, Harrison L. Rogers, Jr., M.D., president-elect; American Psychiatric Association, John A. Talbott, president.

Gentlemen, if you will proceed in the order in which you are listed in your own manner, we will be grateful.

STATEMENT OF HOWARD BERMAN, GROUP VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. BERMAN. Mr. Chairman, I am Howard Berman, group vice president of the American Hospital Association.

I have submitted for the record a full statement, and I would like to use this time to briefly discuss several points.

Access to hospital and other health services is recognized as a necessity for all people. The affordability of health services is similarly a necessity; affordability, in turn, is the key to access.

It is on these basic ideas that the Medicare Program was created. Nearly two decades ago, we made a promise to ourselves that the poor and the aged among us would be assured of access to needed health services. Millions of people have taken that promise to heart and have built their future plans on it. The worth of that promise, however, is dependent on our mutual ability to assure access to needed services.

For almost 20 years now, we have all worked to keep the promise of Medicare. Hospitals in particular have carried a heavy burden. It is at the hospital that much of Medicare takes on substance, and it is at the hospital that the promise of Medicare must be made a reality. If the promise of Medicare is broken, it will not be because of hospitals. Hospitals will continue to provide services to their communities and their patients until there is nothing left for them to give.

As we look to the future, we can all see the problem ahead with respect to the trust fund. Clearly, a deficit looms on the horizon. Whether it be 1992 or 1995, whether it be $150 billion or $300 bil-

lion, the need for Medicare trust fund financial stability is still clear.

The performance of hospitals in the entire health system must be part of a long-term trust fund solution. But just as hospitals must be part of the operating solution, they also must help to shape the overall solution. As the people on the firing line, hospitals have a special obligation to help assure that the steps we take next do not result in failed hospitals and failed answers.

There are really no shrill answers to the Medicare problem. Medical technology and service availability have been, along with general inflation, the driving forces behind the cost increases we have seen. Neither advancing technology nor increased service availability can be seen as the villain. The two forces have together enabled us not only to do more but also to do more for more people. They have enabled the quality of life to be enhanced far beyond that which any of us would have anticipated back in 1965.

In looking to the future, technology and demands for service availability will continue to be cost escalating forces. Added to that will be a larger and older Medicare population. A simple demographic equation makes it clear that in the 1990's more Medicare services are going to be required.

In the face of these pressures, it is important that we act. We must act, however, with a sense of reality. The hospital world which we knew in the past has changed markedly over the last 2 years. Importantly, it has changed for the better. For example, hospital cost increases in real terms are at historically low levels.

Of equal importance is the fact that Medicare admissions, which some had feared would balloon with the implementation of prospective pricing, have not changed from historical trend lines. In fact, year-to-date Medicare admissions are less in 1984 than they were for the same period in 1983.

The incentives of the prospective pricing system are obviously working. More, however, is at work than just PPS. Under 65 admissions and under 65 length of stay are showing even more positive performance. We are working in a different world than we knew 2 years ago. It is a real world, however, which invalidates many old solutions, including some which we have advocated ourselves in the past.

That hospital performance must continue to improve should no longer be debated—it must. That the trust fund can be put into balance simply by paying hospitals less than cost should also be no longer considered or debated as a workable answer—it isn't. It has been estimated that to balance the trust fund on the hospital side alone, cost increases would have to be about half the rate of general inflation. To hold or cut prices to that level, no matter how carefully it is managed, is simply to cut services and deny access.

While the hospital as the supply side must be part of the answer, it clearly by itself cannot be the whole. The long-run solution to the trust fund must involve not only supply-side forces but also the demand-side of the equation. The Medicare benefit package must not be cut, but rather must be retailored and reexamined from the perspective of the lessons and experience of the past 20 years.

No one has a monopoly on answers. We must experiment with new ideas, must take risks, must share our common experiences.

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Paramount, however, is the need to recognize that demand-side reforms are part of the solution we must find.

The supply-side reforms which have been implemented and demand-side reforms which must be pursued are essentially expenditure containment measures. If used properly, they will assure that we get the greatest possible benefit from our Medicare expenditures. If they cut too deeply, they will only result in reduced access to service.

We must not allow that to happen. We must, therefore, move judiciously but also look to the other side of the ledger. As painful as it might at first seem, a viable solution must also involve increasing trust fund revenues. The Advisory Council on Social Security has recognized this difficult but unavoidable need. Again, there is no monopoly on wisdom. Although financial means testing as the basis for benefit eligibility is to be avoided, a number of other mechanisms can be made part of a workable solution.

Finally, we must understand that whatever we do in the Medicare arena will be ineffectual unless we recognize that financial access to care must also be provided for the poor. If each payer only worries about the direct needs of their own beneficiaries, then who will care for the poor? Hospitals will obviously do all that they can to take care of the needy, but economic realities force limits on the hospital's ability to meet this issue on its own.

We cannot allow either the poor or the aged to go without. It was all part of the same promise. For our part, we are committed to pursuing continued improvements in operating performance while at the same time joining with you and others in finding the rest of the answers.

If there are any questions I could answer, I will be glad to try. Thank you.

Chairman JACOBS. Thank you, Mr. Berman.

[The prepared statement follows:]

STATEMENT OF HOWARD BERMAN, GROUP VICE PRESIDENT, THE AMERICAN HOSPITAL ASSOCIATION

SUMMARY

The recent economic performance of the hospital industry strongly supports the American Hospital Association's belief in the effectiveness of incentives to control health care costs. New incentives in the Medicare program, including prospective pricing, along with an enormous amount of innovation in the private sector, have resulted in historically low rates of increase in hospital expenses, with all patients—not just those covered by Medicare—benefitting from the reduction.

Recent efforts to reduce both public and private expenditures for medical care have focused attention on the plight of individuals without private health insurance. Although the current, pluralistic system for financing care for the medically indigent has provided a high level of access, recent cutbacks within the system require careful reconsideration of the roles of public and private programs in meeting the needs of this population. A gradual, evolutionary approach relying on consumer and provider incentives and on the development of innovative financing and delivery systems holds the most promise for solving this problem.

The best solution to the financing problems of the Medicare trust fund is the creation of incentives to bring about desired changes in both consumer and provider behaviors. Such incentives can work, it is important to note, only if the level of Medicare financing is commensurate with the needs of the Medicare population. The recent performance of the hospital industry clearly indicates that properly structured incentives can ensure the best use of available resources.

INTRODUCTION

Mr. Chairman, I am Howard Berman, group vice president of the American Hospital Association (AHA). The AHA, which represents over 6,100 member hospitals and health care institutions, as well as more than 38,000 personal members, is pleased to have this opportunity to present its views.

The Subcommittee has set an ambitious agenda, covering the issues of controlling the rising costs of health care, providing access to health services for the disadvantaged, and assuring the long-term solvency of the Medicare program. Specific proposals before the Subcommittee are, directly or indirectly, responses to public concern with health care costs. The proposals include H.R. 4870 and S. 2424, companion bills (respectively introduced by Rep. Richard Gephardt and Sen. Edward Kennedy) to establish mandatory state or federal rate-setting for all payers; H.R. 3884, legislation (sponsored by Rep. Ronald Dellums) to establish a national health service; and reforms proposed by the Advisory Council on Social Security in its report on the future of Medicare.

While health care costs have increased enormously over the past two decades, they have been accompanied by enormous strides in providing better access to services for the poor and elderly, and in treating formerly "incurable" diseases such as heart disease and cancer. In addition to offering such benefits, these advances have created both economical and ethical problems. For example, the recent controversy over "Baby Doe" could not have occurred ten years ago simply because it was not possible then to keep a severely handicapped infant alive. For another example, progress in transplantation medicine is raising questions about coverage and price. In dealing with the issue of health care costs, the level of costs is important, but the services patients receive as a result of these costs are more significant.

Government occupies a particularly crucial position in the debate over health costs and policies. As a major purchaser of services, government has a direct and obvious interest in containing the rate of increase in costs. It also has great opportunities to modify directly the behaviors of providers, beneficiaries of government programs, and consumers who rely on private resources. While government can also use its regulatory power to bring about behavioral modifications, it can act more effectively in bringing about changes by acting as a prudent, yet fair, purchaser and by establishing appropriate incentives.

INCENTIVES AND ECONOMIC PERFORMANCE

The effectiveness of incentives in altering behavior is amply demonstrated by the recent performance of the hospital industry. During 1983, the rate of increase in total hospital expenses was 10.2 percent, down from a 15.8 percent increase in 1982. The reduction in inpatient expenses was even greater: from 15.6 percent in 1982 to 9.6 percent in 1983. A large part of the reduction must be attributed to changes in incentives that were introduced by Medicare in 1982 and 1983 and that were strengthened by the implementation of Medicare prospective pricing in the fall of 1983. These incentives were complemented by changes in the private sector, which must share in the credit for improved performance.

During the first five months of 1984, the trends are even more dramatic. The annualized rate of increase in inpatient expenses for the first five months of the year is only 4.1 percent. The sharp reduction in rates of increase cannot be attributed solely to lower inflation. As trends in hospital employment and length of stay indicate, a substantial part of the industry's performance in 1984 is due to improvements in hospital efficiency in both the production and use of hospital services.

The trend in hospital employment is one of the most striking changes in hospital economic performance. While total employment rose 3.7 percent in 1982, it increased just 1.4 percent in 1983. During the first five months of 1984, the annualized rate of decline in employment was 1.0 percent.

Admission and length of stay trends are equally dramatic. Total admissions declined one-half of 1 percent during 1983, although admissions of patients 65 years of age and older increased 4.7 percent. Length of stay for patients 65 years of age and older declined 4.5 percent during 1983. During the first five months of 1984, total admissions declined at an annualized rate of 3.1 percent, while admissions of patients 65 years of age and older declined at an annualized rate of 1.2 percent. Length of stay for patients over 65 declined at an annualized rate of 7.5 percent during this period. Similar trends in utilization are shown also by the under-65 population, reflecting the widespread changes that are occurring in the financing and delivery of health care in the private sector.

The significance of these trends is readily apparent. First, hospitals are responding to incentives created by Medicare's new payment system. Second, real savings

are being generated for both Medicare and for other payers—even though these payers do not use Medicare's payment system. Finally, these changes have occurred with little change in Medicare beneficiary incentives, although changes in the benefit design of private insurance have increased consumer cost consciousness.

THE INCENTIVES APPROACH

The health care financing and delivery system in the United States is pluralistic, and has evloved under the direction of local organizations responding to local needs and conditions. This system is responsive to changing consumer preferences, and enables government to limit its involvement in the financing and delivery of care to those areas where it is most needed. Its responsiveness is reflected in the development of Blue Cross plans, health maintenance organizations (HMOs), and commercial insurance, all of which emerged from the private sector.

The continuing responsiveness of the system can be seen in the current rapid evolution of new concepts of payment, delivery, and insurance. Many private insurers are experimenting with prospectve pricing systems and with alternative designs of health insurance benefits. Possibly the most widely discussed new concept in health care financing and delivery is the preferred provider organization (PPO), which presently is under development in nearly all parts of the country and in all kinds of communities. The key characteristics of the PPO is a combination of delivery alternatives and consumer incentives to meet the needs of a particular employee group. Both the services covered and the ways of delivering the services vary from plan to plan, which ensures a high degree of responsiveness to the needs of the special groups involved.

Another recent development, local health care coalitions, represents a promising means of bringing about the effective collaboration of providers, insurers, employers, and organized labor to contain health care costs. The Community Programs for Affordable Health Care project, sponsored by the Robert Wood Johnson Foundation, is stimulating innovative efforts to develop local health care financing and delivery systems that are responsive to community needs and resources. Many of these programs have also identified access to care for the economically disadvantaged as a priority.

THE REGULATORY ALTERNATIVE

H.R. 4870, the bill introduced earlier this year by Rep. Gephardt (and S. 2424, sponsored by Sen. Kennedy), relies on regulation to achieve the objectives of cost containment and access to care. If enacted, it would create elaborate federal and state administrative mechanisms to set expenditure levels for each state, to evaluate the performance of state rate-setting programs, and to regulate utilization and prices. While the bill encourages states to develop their own rate-setting methods, the states would have no discretion as to the level of expenditure that would be permitted, and would have no practical alternative to administering a state-operated version of the federal program.

The AHA primarily objects to H.R. 4870 for a very simple reason: the bill is unnecessary. The basic assumption of its authors, that only a uniform system of payment applied to all payers is effective in containing costs, has been shown by the recent performance of the hospital industry to be wrong. Private patients and state Medicaid programs not only are benefitting from the responses of hospitals to the new incentives of the Medicare program but also are reshaping their own incentive mechanisms. Improvements in performance are being reflected at the consumer level, as shown by these examples:

Recently, two hospitals in Chicago, the Illinois Masonic Medical Center and Columbus-Cuneo-Cabrini Medical Center, have announced major reductions in hospital room rates;

For the first time in 17 years, Blue Cross/Blue Shield of Kansas will not request a rate increase (initally, the Kansas plan had planned to ask for a 10 percent increase); and

Blue Cross/Blue Shield of Iowa has reduced rates for one third of its subcribers.

These developments have been made possible largely by lower rates of increase in hopsital costs that are the result of incentives created by competitive measures; Medicare payment incentives; and various innovative private sector payment systems, each tailored to local needs and capabilities.

In addition, the AHA believes that H.R. 4870 calls for radical changes in current payment systems without consideration of the substantial administrative problems that these changes would create, and without knowledge of the consquences of such changes on the availability of services in many communities. Although all the data

needed to implement the Medicare hospital prospective pricing system have been collected for several years and are readily available, its implementation has been a major task and a number of equity issues posed by it have not been resolved. Putting in place the far more ambitious system proposed in H.R. 4870 would require data that do not exist at the present time. Even if there were data to estimate prices, the methods to be used to set them are not spelled out in detail. Moreover, the impact of H.R. 4870 on teaching hospitals, referral hospitals serving rural communities, and hopsitals offering specialized services cannot be evaluated.

Also, it is impossible to estimate the impact of H.R. 4870 on Medicare, state Medicaid, or private expenditures. The estimated savings presented by the bill's authors have been substantiated and could be achieved only by radically reducing provider payments or restricting utilization.

Most importantly, H.R. 4870 would slow the pace of innovation already occurring in the private sector. The bill attempts to encourage the information of "alternative delivery systems" by fostering enrollment in HMOs through cash rebates to enrollees. The bill also attempts to establish an incentive for providers to form HMOs. By limiting these incentives to HMOs and competitive medical plans (CMPs), the bill does not recognize the wide range of new financing and delivery systems that are being developed in the private sector, i.e., PPOs, which do not fit the definition of an HMO or a CMP. Nor does the bill recognize the wide range of new payment systems that are emerging in the private sector that are tailored to the needs and capabilities of particular communities.

For all these reasons, the Association is opposed to the provisions of H.R. 4870.

NATIONAL HEALTH SERVICE

H.R. 3884, Rep. Dellums' bill to establish a national health service, emerges from an understandable concern with providing access to care for those segments of the population that lack private resources. His bill, however, calls for a complete restructuring of the pluralistic delivery system that has evolved in this nation.

Although gaps continue to exist, the combination of public and private mechanisms for financing the care of those individuals lacking private resources had provided a high level of access to needed medical care. Recent pressures to restrain government expenditures and to reduce payments to providers have limited providers' ability to finance the care of the medically indigent and excluded many of the poor from public programs. Ensuring access to care for the medically indigent and equitably distributing the burden of financing that care are objectives that can and should be reached by changes in existing public and private financing mechanisms. A complete restructing of the medical system is unnecessary, and would abruptly end the current period of innovation in the development of financing and delivery systems.

The AHA this week is submitting testimony to the National Health Planning Council on the topic of financing care for the medically indigent and would be pleased to provide a copy to the Subcommittee. In that testimony, we note that the reasons for increasing public concern with medical indigence are the lack of adequate public financing for the Medicaid program, the failure of public programs to bear part of the cost of financing uncompensated care, and growing pressures for private insurers to follow Medicare's lead and limit their responsibility for uncompensated care. The best strategies for resolving the problems of both access and costs will be those that rely on incentives to bring about changes in behavior at the local level. Only local organizations have the knowledge of community needs and resources that is basic to the development of innovative, responsive programs.

MEDICARE SOLVENCY

The Advisory Council on Social Security, earlier this year, presented its recommendations on the future of the Medicare program. The council acknowledged that a profound imbalance between program revenues and expenditures will emerge early in the next decade. In recommending solutions to this problem, the council rejected increases in either payroll taxes or general revenue contributions to generate additional revenues. The council approved the reallocation of revenues between the Old Age Survivors' and Disability Insurance and Hospital Insurance trust funds to generate additional financing, as well as the use of a premium on a new supplemental benefit, the imposition of a limit on tax deductible health insurance premiums, and enactment of excise taxes on alcohol and tobacco.

To reduce expenditures, the council suggested an increase in the age of eligibility and a restructuring of the Part A benefit. Under the new benefit, consumer cost-sharing would be modestly increased, and the limits on coverage would be raised.

The council recommended that no effort be made to tie entitlement to the financial status of beneficiaries. Moreover, the council endorsed the concepts of health promotion, the development of a voluntary voucher, and a series of proposed changes in payment policies: To limit increases in prospective prices to the hospital market basket; to eliminate payment for medical education costs; to implement physician payment based on fee schedules; and to replace the assignment concept with a "participating provider" plan.

The problems facing the Medicare trust fund do not have simple solutions, because they arise from the changing demographic structure of the population and the basic relationship between aging and the need for medical care. In a sense, the trust fund's problems are measures of success—of the Medicare program in expanding access and in treating many of the diseases associated with age. The program's projected financial shortfall necessitates a careful evaluation of both the causes of rising Medicare expenditures and the available alternatives for restoring financial soundness of the trust fund. Any solutions that are ultimately adopted must be consistent with the basic purpose of the program, to provide the elderly with access to needed medical care, with equitable sharing of the costs of the program by all segments of the population.

Many of the council's recommendations are consistent with thsese two goals. The council clearly recognizes that some increase in revenues will be necessary if the program is to meet the goal of providing access to care for the nation's elderly. While the economic status of the elderly has improved in recent decades, a substantial number of Medicare beneficiaries have incomes well below the national average. Many of these beneficiaries also have the greatest need for medical care.

The council also recommends a number of measures to reduce projected expenditures. Several of these measures, i.e., the proposed increases in consumer cost-sharing, would establish consumer incentives that are consistent with more cost-effective use of medical services. At the same time, the expanded coverage for "catastrophic" illness would provide better protection for beneficiaries with the most limited resources. However, the majority of the council's expenditure reduction recommendations would simply and arbitrarily reduce Medicare payments to providers.

Of most concern to the AHA is the recommendation to increase Medicare diagnosis-related-group prices by only the rate of increase in the hospital market basket, eliminating any factor for technology. This policy, while generating substantial projected "savings" over the next 25 years, would lead to prices that fall short of the cost of the services needed by Medicare beneficiaries. The AHA, as indicated to members of this Subcommittee during conference deliberations on the Deficit Reduction Act, opposes elimination of the technology factor from price-setting calculations because it would lead to reduced access to current "state-of-the-art" medical care for Medicare beneficiaries and other patients.

The second recommendation of the council of major concern to the AHA is the elimination of Medicare payment for the costs of medical education. The AHA views medical education as, in reality, inseparable from patient care. Exclusion of medical education costs from Medicare payments would compel many teaching hospitals to curtail radically the services they make available to both Medicare beneficiaries and other population groups. As these hospitals, and the services they offer, are used by the patients with the greatest medical needs, the result of this policy would be significant reductions in access to care.

The AHA is committed to working with this Subcommittee and with the Congress to develop fiscally sound solutions to the financial problems of the Medicare trust fund. The Association is currently working to increase the awareness of the current and projected position of the trust fund among its hospital members. The development of a sound package of reforms will require much analysis, as well as a careful balancing of competing objectives. As the AHA pursues its studies, its membership looks forward to a continuing dialogue with both the Committee on Ways and Means and other congressional panels, as well as with the Department of Health and Human Services and with representatives of Medicare beneficiaries.

CONCLUSION

Mr. Chairman, the AHA appreciates this opportunity to present its views. The issues addressed in this hearing have both short- and long-term significance. The AHA believes that the best solutions to Medicare funding problems lie in the creation of financing systems that rely on incentives to bring about desired changes in both consumer and provider behaviors. These incentives can work, however, only if the level of financing is commensurate with the needs of the populations dependent upon the public sector for the financing of their medical care. The recent perform-

ance of the hospital industry clearly indicates that properly structured incentives can ensure that the best use will be made of the resources that are made available.

Chairman JACOBS. Dr. Rogers.

STATEMENT OF HARRISON L. ROGERS, JR., M.D., PRESIDENT-ELECT, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY HARRY N. PETERSON, DIRECTOR, DIVISION OF LEGISLATIVE ACTIVITIES

Dr. ROGERS. I am Harrison Rogers. I am a physician in the practice of surgery in Atlanta, GA, and I am president-elect of the American Medical Association. Accompanying me today is Harry N. Peterson, director of the AMA's Division of Legislative Activities. The American Medical Association is pleased to have this opportunity to present testimony on Medicare financing, recommendations for Medicare reform, and H.R. 4870.

I have submitted a longer statement for the record, and I will summarize it briefly. There are certain basic forces driving the program toward financial crisis which include an aging population, high per capita health care costs for the elderly, decreasing proportion of workers to beneficiaries, inability of government to meet all its obligations and promises, rising total health care costs, expanding medical technology, increasing professional liability costs and general inflation.

The American Medical Association is committed to the provision of the highest possible quality care for Medicare beneficiaries. To assure viability of this into the future, the AMA is in the process today of conducting a detailed review of the Medicare Program to develop recommendations for long-term program modifications.

As part of this project, we have developed a series of recommendations designed to help assure short-term solvency of the Medicare Program. These recommendations are spelled out in our full statement. They relate to three general areas.

First, they would relate to an increase in revenues in order to shore up the hospital trust fund. This could be accomplished by a moderate one-time increase in the hospital insurance tax, an increase in tax rates for alcohol and tobacco products, and by broadening the insurance tax base by including some nonwage income.

Second, we feel the necessity of preserving the availability of the Medicare Program for all of our elderly requires a look into the basic chacteristic of the program insofar as the beneficiaries contribute to the program expenses.

In our view the basic entitlement should not be altered so that the program remains equally available to all the elderly. However, adjustments should be considered so that premium contributions, as well as deductibles and coinsurance, would relate to the ability of beneficiaries to respond according to their income, with adequate protection for the poor.

Third, we believe the age of eligibility of Medicare should be reviewed with periodic increases in the age for eligibility to reflect changes in longevity and in health and in employment status.

The AMA believes that implementation of these recommendations will provide meaningful program modifications to address the short-term financial problems facing the Medicare Program.

The Advisory Council on Social Security filed a report with the Secretary of HHS in late 1983 which contained a series of recommendations for modifications to the Medicare Program. The AMA has reviewed these recommendations, and our comments on these are contained in our full statement.

H.R. 4870, the Medicare Solvency and Health Care Financing Reform Act of 1984, provides for a radical restructuring of reimbursement for inpatient services for both hospital and physician services. It is not restricted to payments under Medicare and Medicaid, but creates reimbursement limitations affecting each hospital's total revenues, regardless of payer source.

The AMA carefully studied this complex bill. We urge its rejection. The bill calls for a radical restructuring of the payment mechanism for health care delivery throughout the country without the benefit of even a single demonstration as to how such a system could work and what effects it would have on the health care delivery and health status of the population.

The bill would result in rationing of health care services for individuals in need of hospital care, because of its arbitrary establishment of hospital revenue caps. By capping hospital revenues and imposing heavy penalties based on preset revenue and admissions limits, the bill would squeeze potential revenues per case, and hospitals would be forced to cut back on the availability of care or impose rationing to make ends meet. The bill would establish incentives for hospitals and physicians to reduce services, a goal usually tied to a reduction in overall quality of health care services.

Our specific objections to this legislation are detailed in our full statement.

In conclusion, the AMA urges this subcommittee and the Congress to continue to recognize the commitment made to the elderly and disabled of this Nation, to assure access to high-quality medical care.

We urge you to carefully evaluate and accept the recommendations we have made for short-term modifications in the Medicare Program. We believe that enactment of such modifications can provide sufficient time free from the pressures of short-term budget and fiscal constraints to develop appropriate long-term approaches.

Thank you very much. I would be glad to respond to any questions.

Chairman JACOBS. Thank you.

[The prepared statement follows:]

STATEMENT OF HARRISON L. ROGERS, JR., M.D., PRESIDENT-ELECT, AMERICAN MEDICAL ASSOCIATION

Mr. Chairman and Members of the Subcommittee; my name is Harrison L. Rogers Jr., M.D. I am a physician in the practice of surgery in Atlanta, Georgia, and I am President-Elect of the American Medical Association. Accompanying me today is Harry N. Peterson, Director of the AMA's Division of Legislative Activities. The American Medical Association is pleased to have this opportunity to present this testimony on Medicare financing, recommendations for Medicare reform, and H.R. 4870.

HISTORICAL PERSPECTIVE ON THE MEDICARE PROGRAM

Medicare and Medicaid were enacted at the beginning of a period marked by expansion of federal involvement in social programs. The "Great Society" programs of the mid-sixties embraced new segments of the population and provided a wide array

of social services. A variety of health programs were included. For many years "health" was a fundamental issue commanding a prominent place in the political scene. Almost limitless funds were being allocated into varying aspects of the health system:

Basic research was greatly expanded resulting in new scientific breakthroughs technology.

Hospitals modernized and expanded throughout the country as a result of the Hill-Burton program of federal financial assistance.

Health manpower development burgeoned with expansion of federal assistance to medical and allied health schools and their students.

It is within the context of expanded federal assistance for facility development, for manpower expansion, for health research and dissemination of medical knowledge, and expansion of alternative delivery systems that the federal medical programs providing payment for medical services completed a circle of large-scale encouragement and direct financial support for the health care system.

During the decade or so following enactment of Medicare and the expectations of the nation's elderly for health care coverage through Medicare grew. These expectations were recognized by the Congress, which reacted to a variety of pressures, including those of an increasing elderly population. Congress expanded the Medicare program, and extended coverage to new population groups—the disabled and those with end-stage renal disease (ESRD). The Congress had clearly made a major commitment to large segments of the U.S. population that high quality care would be made available and paid for. Health care as a "right" became a central theme in the 1970s in discussions on health care. What was created was a situation of expanding beneficiary rolls and increased beneficiary expectations. During this era primary attention was focused on quality rather than costs.

In the main these developments occurred in an era of relative national affluence. But because of program expansion, the cost-based reimbursement methodology under Part A, the increase in numbers of Medicare beneficiaries and in per capita use of covered services, the rapidly expanding availability of providers, and the growing rate of inflation in the economy as a whole, the costs of Medicare were escalating sharply.

Unfortunately, the economic vitality of the country did not keep pace with increasing demands of federal programs and expenditures. The federal government is now faced with serious economic problems, including growing budget deficits. In the light of many economic, social and technological changes, Medicare is coming under close scrutiny. Because of increasing annual federal deficits, fundamental changes—even the mention of which would have been unthinkable only a few years ago—are now freely discussed in many quarters and are the subject of this hearing today.

FORCES DRIVING PROGRAM TO FINANCIAL CRISIS

Mr. Chairman, there are certain basic forces driving the current program toward financial crisis, including: an aging population; high per capital health care costs for the elderly; the decreasing proportion of workers to beneficiaries; the inability of government to financially meet all its obligations and promises; rising total health care costs; expanded medical technology; increasing professional liability costs; and general inflationary measures.

Several important observations in this area are:

In the next fifty years the population over 65 will more than double and the population over 85 will more than triple.

The ratio of workers to elderly will decrease form 5:1 in 1990 to 3:1 in 2025.

As the proportion of older people in the population increases, the requirements for acute and long-term care will increase.

Although the elderly comprise 11% of the total population, they make 30% of all patient visits to office-based physicians.

Forty percent of total hospital inpatient days are used by elderly patients. In 1978 short-stay hospital admissions for persons age 65 and over were about 350 per thousand population, while for those under 65 the figures were about 132 per thousand population. Older patients have an average length of stay 76% greater than younger adults.

The elderly occupy 90% of nursing home beds.

Persons over 65 incurred 3.5 times the per capital health care expenditures of persons under age 65. Almost two-thirds of these expenditures are covered through Medicare and Medicaid.

Over 97% of private nursing home expenditures are out-of-pocket expenses for the aged and their families, uncovered by Medicare or private insurance.

Between 60% and 80% of the long-term care the disabled elderly receive in the community is provided informally by a spouse, other relatives, and/or friends. The presence of a spouse and/or children is the most important factor determining whether or not a disabled elderly patient will enter a nursing home.

MEDICARE RECOMMENDATIONS

The creation of the Medicare program in 1965 was a commitment to the elderly that this nation would assure them access to, and meet the major part of the cost of, high quality health care services. To a large extent that promise has been met.

The 18 years since the enactment of Medicare have seen tremendous improvement in not only access to and the availability of high quality health care but also in the health care status of the covered population. One of the principal reasons why the Medicare program has been able to accomplish these important twin goals of easy access to high quality care and improved overall health status has been the ability of the Medicare beneficiary to receive care in the same mainstream fashion as other individuals.

The American Medical Association is committed to the provision of the highest possible quality of care for Medicare beneficiaries. To assure the viability of this commitment into the future, the AMA is in the process of conducting a detailed review of the Medicare program to develop recommendations for long-term program modifications. As part of this project, we have developed a series of recommendations designed to help to assure the short-term solvency of the Medicare program. The recommendations include:

A moderate one-time increase in the payroll tax rate on employers and employees.

An increase in the present rates for alcohol and tobacco products with the additional revenues from these new taxes directed to the Hospital Insurance Trust Fund.

Imposing the health insurance tax on the non-wage income of individuals above a certain threshold and up to the taxable maximum.

Imposing a Part A premium on Medicare beneficiaries based on beneficiary income that is above a certain level.

Imposing a coinsurance requirement on beneficiaries for Part A hospital expenses up to a specified cost-sharing limit, with the cost-sharing amount varying according to beneficiary income.

Periodically increasing the age of eligibility for Medicare to reflect changes in longevity, health, and employment status, with special consideration given to the coordination of eligibility dates for Medicare and Social Security cash benefits and a continuation of private health insurance coverage for those who retire prior to attaining Medicare eligibility due to age.

Increasing the Part B premium to a level adequate to fund 35% of costs, with consideration to be given to relating the premium amount to the income status of beneficiaries.

The AMA believes that implementation of these recommendations will provide meaningful program modifications to address the short-term financial problems facing the Medicare program.

The Association is now continuing its intensive review of the Medicare program, as well as overall issues surrounding the delivery of health care for the elderly and disabled for the long-term. We will be pleased to share with this Subcommittee the further results of our study and recommendations for future changes.

RECOMMENDATIONS OF THE ADVISORY COUNCIL ON SOCIAL SECURITY

The Advisory Council on Social Security forwarded a report to the Secretary of the Department of Health and Human Services in late 1983. The Report contains a series of recommendations for modification to the Medicare program. These recommendations were the subject of the Subcommittee's March 30, 1984 hearing. The AMA has reviewed the recommendations and our comments are attached to this statement as an Appendix.

H.R. 4870—THE MEDICARE SOLVENCY AND HEALTH CARE FINANCING REFORM ACT OF 1984

H.R. 4870, the "Medicare Solvency and Health Care Financing Reform Act of 1984," (introduced in the Senate by Senator Kennedy as S. 2424 and referred to as the "Kennedy-Gephardt" bill) provides for a radical restructuring of reimbursement for inpatient services for both hospital and physician services. It is not restricted to

payments under Medicare and Medicaid but creates reimbursement limitations affecting each hospital's total revenues regardless of the payor source.

BACKGROUND

The bill would create "incentives" for states to develop plans to limit total hospital revenues for all services provided to hospital inpatients. The proposal creates a punitive residual federal program, which would be effective in states failing to adopt programs meeting standards set in the bill. A state plan must meet objectives of the federal plan and be approved by the Secretary of HHS. Total hospital revenues would be capped statewide at a level that would be set if the residual federal program was in operation, and individual hospitals would have limits set on reimbursement per discharge. This amount would include both hospital and physician services. State plans would be obligated to create mechanisms to provide payment for hospital care for under-insured and uninsured individuals, plans would also have to provide an exemption from the program for health care facilities owned or controlled by or serving individuals who are predominantly members of HMOs or other "eligible" organizations.

A residual federal program would provide for a prospective payment limit on all inpatient hospital services based on a diagnosis-related group (DRG) in states without a state plan in operation. In addition, total revenues for inpatient services for each hospital would not be allowed to exceed a predetermined limit without penalty. The bill would also substantially modify inpatient physician payment mechanisms for Medicare beneficiaries by requiring that all payments for physician services be based on DRGs and be made through the hospital in the absence of other arrangements. Assignment would be mandated for all physician services.

The bill also provides a series of "competition" proposals intended to encourage individuals to receive care through an HMO or other "qualified" plan.

COMMENTS

The AMA has carefully studied this complex bill. We urge its rejection.

The Kennedy-Gephardt bill calls for a radical restructuring of the payment mechanisms for health care delivery throughout the country without the benefit of even a single demonstration as to how such a system could work and what effects it would have on health care delivery and the health status of the population. The very fact that the bill calls for studies as to how to maintain a high quality of services while constraining the rate of increase in costs only points to the fact that the bill is "putting the cart before the horse." Its stress is totally on cost-containment. There is hardly a word on quality of or access to care.

The AMA is also cognizant of health care costs. AMA has been active in this area for years. In 1976, the AMA's National Commission on the Cost of Medical Care issued numerous recommendations in the health care area that have become the basis for many of the proposals now being considered to hold down health care costs. The AMA has numerous programs designed to encourage physicians to practice cost-effective medicine. We continue to work with the business community through active support of health care coalitions.

The bill would result in a rationing of health care services for individuals in need of hospital care because of its arbitrary establishment of hospital revenue caps. By capping hospital revenues and imposing heavy penalties based on preset revenue and admissions limits, the bill would squeeze potential revenues per case, and hospitals would be forced to cut back on the availability of care or impose rationing to make ends meet. The bill would establish incentives for hospitals and physicians to reduce services—a goal that is usually tied to a reduction in the overall quality of health care services.

In addition, the AMA specifically objects to the Kennedy-Gephardt bill for the following reasons:

The bill would penalize hospitals that have any increase in admissions over their previous admission average. (Medicare would allow only marginal cost reimbursement, 40% of the DRG or 50% in states with a state plan, for all admissions in excess of the number of admissions set by the hospital's base period). While the program would allow for the Secretary to take into account admissions in excess of this period that are "extraordinary and due to circumstances beyond the hospital's control," there is no leeway for full reimbursement for additional admissions where those additional admissions may indeed otherwise also be appropriate.

The bill would mandate assignment for all physician services for Medicare beneficiaries. The concept of mandated assignment is unnecessary given the past history

of Medicare assignment. By mandating assignment, physicians would be discouraged from participating in Medicare, and patient access could be hindered.

The bill creates an Advisory Committee on Health Care Technologies and Procedures that is directly tied to a system of controlled budgets and further creates the potential for rationing of health care. (The Advisory Committee would be required to examine the appropriateness of various medical interventions, the safety and efficiency of alternative therapeutic and preventive regimens, and provide standards of availability and utilization of technologies. The committee would then be empowered to "publicly report" on whether or not payments should be made for such services and the conditions and frequency of service.) The operation of this committee in a cost-containment program will most likely emphasize only cost considerations in making reports on coverage for new technologies and procedures. The primary determinant of coverage should be the potential benefit to be derived from the service, and this can best be determined with credibility and objectivity by local groups and institutions.

States would find it difficult to develop an individual program in terms of both costs and administrative feasibility. State programs would have to meet stringent federal requirements established in the law that would set reimbursement limits for all services provided to hospitalized patients. This would require states to develop a maximum amount of payment per discharge that would account for both the costs of hospitalization and physician services. The AMA questions the feasibility and cost of developing such a payment rate. It has not been done previously for physician service, and an average cost per discharge of hospital care has only recently been determined for Medicare beneficiaries.

Because of civil penalties under the Federal program, hospitals in a growing community will have no incentive to expand the scope of care they provide or to attempt to market their services to a larger portion of the population. Any such expansion or extension of the hospital's population base could result in a net increase in the institution's total inpatient revenues, causing imposition of penalties.

The federal program would also penalize hospitals for attempting to increase their population base as they would only be reimbursed at a marginal rate (60% of the allowed rate) for all discharges that are in excess of a base number of discharges determined by the hospital's previous accounting records. This penalty acts to provide a strong disincentive for a hospital to work to increase its population base and increase the availability of its services to the local community.

If enacted, the Kennedy-Gephardt proposal would inevitably spawn an enormous amount of federal regulations to implement, monitor and enforce the law. Enormous resources would be required in the private sector to operate in the environment created by the bill. This complexity alone increases the risks of unintended or marginal results. The very complex nature of the proposal could also threaten the efficient delivery of health care in this country by inappropriately diverting the resources and attention of those individuals responsible for providing health care. The AMA does not believe that the Kennedy-Gephardt proposal is a responsible approach for the future of health care delivery in America.

CONCLUSION

The AMA urges this Subcommittee and Congress to continue to recognize the commitment made to the elderly and disabled of this nation—to assure access to high quality medical care. We urge you to carefully evaluate and accept the recommendations we have made for short-term modifications in the Medicare program. We believe that enactment of such modifications can provide sufficient time, free from the pressures of short-term budget and fiscal constraints, to develop appropriate long-term approaches. We are continuing our efforts to identify reforms to assure a comprehensive approach for dealing with the long-term issues concerning the assurance of access to high quality health care for the elderly and disabled.

At this time, Mr. Chairman, I would be pleased to respond to any questions that you or other members of the Subcommittee may have.

APPENDIX

AMA COMMENTS ON RECOMMENDATIONS OF THE ADVISORY COUNCIL ON SOCIAL SECURITY

1. General revenue contributions to the hospital insurance trust fund.—The Advisory Council recommends opposition to any increase in the use of general revenues to finance the Medicare hospital (Part A) trust fund.

Comment: The AMA agrees with the Advisory Council's recommendation. However, as discussed later, certain tax money now directed to general revenue (alcohol and tobacco taxes) could be earmarked for the Part A trust fund.

2. Interfund borrowing.—The Advisory Council recommends that short-term interfund borrowing among the trust funds should be allowed when deemed necessary. Such borrowing should be subject to appropriate safeguards which include authority for each fund to borrow from the others, specific repayment schedules and prohibition against reducing the lending fund's assets below an actuarially acceptable level.

Comment: The AMA supports the Advisory Council's recommendation.

3. Taxation of employer-provided health insurance.—The Advisory Council recommends passage of the Administration's proposal to tax employer's contributions to employee health benefit plans that exceed $70 a month for an individual and $175 a month for a family. The Advisory Council also recommends that a certain portion of the increased revenue should be earmarked for the Health Insurance (HI) Trust Fund.

Comment: The AMA has for some time advocated a limitation on the amount of contributions by employers for health benefit plans that may be deducted as a business expense, and accordingly the AMA supports the Advisory Council's recommendation. Such a tax cap can provide an incentive toward more prudent purchase of health insurance. We oppose the earmarking of such funds for the Medicare program.

4. Raising revenues for the HI trust fund through increased earmarked Federal excise tax and alcohol and tobacco products.—The Advisory Council recommends that the federal excise tax on alcohol and tobacco be increased with the increased revenue earmarked for the Medicare HI Trust Fund. (No specific saving figure was set, as the Advisory Council indicated that Congress should set the level of such excise taxes.)

Comment: The AMA supports the Advisory Council's recommendation.

5. Payroll tax.—The Advisory Council opposes any further increase in scheduled health insurance payroll taxes.

Comment: The AMA does not agree with the Advisory Council's recommendation. We believe that some increase in the health insurance payroll tax is necessary. However, this increase should be considered as only a part of an integrated program to increase revenues and reduce expenditures, as appropriate, under the program.

6. Reallocation of payroll taxes between OASDI and HI.—The Advisory Council recommends that, if needed, consideration be given to reallocation of payroll tax rates between the OASDI and HI Trust Fund in order to transfer any surplus in the OASDI trust fund to the HI Trust Fund for the period of 1985 through 1995.

Comment: The AMA supports in part the Advisory Council's recommendation. In our view Congress should retain this authority and not grant it to the Secretary of HHS.

7. Advance the age of eligibility for medicare benefits.—The Advisory Council recommends increasing the age of eligibility for Medicare from age 65 to 67. The age of eligibility would be increased by three-month increments per year starting in 1985, escalate to six month increments in 1989, with final implementation by January 1, 1990. Thereafter, the age of eligibility should be indexed to increase in life-expectancy.

Comment: The AMA supports the recommendation of the Advisory Council in concept. A mechanism is necessary, however, to assure coverage during any period of time when a beneficiary would be eligible for Social Security cash benefits and ineligible for Medicare.

8. Diagnosis and treatment-related coverage under Medicare.—The Advisory Council opposes further extension of Medicare coverage, by reason of medical diagnosis, to individuals not already eligible.

Comment: The AMA supports the recommendation of the Advisory Council.

9. Restructure of Medicare Part A hospital insurance and an enhanced Part A benefit financed by an annual premium.—This recommendation would provide for catastrophic care protection based on increased premiums. The use of premiums instead of increased cost-sharing as a financing mechanism would mean that all beneficiaries would share equally in the expense, instead of just those who are hospitalized. The proposal consists of three parts as follows:

(A) Restructure Medicare Part A hospital insurance to provide for unlimited hospital inpatient days per calendar year, a per admission deductible as currently computed (limited to two hospital admissions per calendar year), a daily coinsurance equal to 3% of the hospital inpatient deductible for all inpatient days after the first day, a skilled nursing benefit of 100 days per calendar year with no coinsurance on

days 1-20 and a 12½% coinsurance on days 21-100, retention of the currently available home health benefits under Medicare Part A and the current hospice benefit.

Comment: The AMA supports the Advisory Council's recommendation for coinsurance and catastrophic coverage in principle.

(B) The Advisory Council also recommended an optional enhanced Part A insurance benefit to be financed by a Part A premium added to the Part B premium. The new premium would also include an additional base amount to provide additional revenues to reduce the projected Part A deficit. All beneficiaries who elect Medicare Part B coverage would be required to accept this enhanced benefit. The benefit would consist of elimination of the 3% daily coinsurance on hospital inpatient days and elimination of the coinsurance on days 21-100 in skilled nursing facilities.

Comment: The AMA does not support the Advisory Council's recommendation. Supplemental coverage is currently available from the private sector.

(C) The Advisory Council recommends a voluntary enhanced Part B benefit to be offered on an optional basis that would provide a $200 yearly stop-loss on Part B out-of-pocket expenses. This expanded benefit would be financed by an increase in the Part B premium.

Comment: The AMA opposes the Advisory Council's recommendation. Coverage is available in the private sector.

10. Long-term care.—The Advisory Council recommends that the HHS Secretary, in developing a comprehensive long-term care program, seek guidance from studies which have suggested targeting of groups that would benefit from those services.

Comment: The AMA supports the Advisory Council's recommendation.

11. Preventive care services.—The Advisory Council recommends a comprehensive review of HCFA's demonstration projects to assess the economy and efficacy of expanding Medicare coverage to include preventive services to be undertaken prior to any change in the law.

Comment: The AMA supports this recommendation.

12. Voluntary vouchers.—The Advisory Council recommends the use of voluntary vouchers in the Medicare program.

Comment: The AMA does not support the Advisory Council's recommendation for full implementation of a voluntary voucher program. We do support appropriate demonstrations of voucher programs prior to nationwide implementation.

13. Indexing supplementary medical insurance deductible.—The Advisory Council recommends that the current Part B deductible be indexed to the Consumer Price Index (CPI).

Comment: The AMA supports the Advisory Council's recommendation for indexing, but recommends such indexing be tied to the Medical Care Component of the CPI.

14. Prospective payment.—The Advisory Council recommends that the allowed increase for hospital costs under the DRG system (market-basket plus 1% for technology and intensity of services) should be modified to reduce the allowable 1% increase for technology and intensity.

Comment: The AMA opposes reduction in benefits that should be available for improvements in technology and patient care. (*NOTE:* This increase factor was reduced by PL 98-369.)

15. Medicare medical education expenses.—The Advisory Council recommends that the cost of training medical personnel should not be borne by the Medicare program. The Advisory Council believes that such support should be through other sources.

Comments: The AMA opposes the Advisory Council's recommendation. Medicare should maintain its share of responsibility for costs of medical education, the benefits of which redound to all patients.

16. Medicare reimbursement for physician services.—The Advisory Council recommends elimination of the current usual-customary-reasonable formula. The Advisory Council recommends that as a step toward system reform the Medicare statute should be amended to authorize development of fee schedules, adjusted initially and periodically for differences in cost of living and/or maintaining a practice.

Comment: The AMA is opposed to arbitrary fee schedules. We support a pluralistic approach to third party payment methodology under fee-for-service. We are also currently reviewing various means for physician reimbursement. Congress has already mandated two ongoing studies reviewing physician reimbursement.

17. Assignment of Medicare benefits for physician services.—The Advisory Council recommends that physicians be allowed to enter into participation agreements with the Medicare program whereby the physician would accept assignment for all services to Medicare patients. Those who did not enter into such agreement would be barred from accepting assignment for any claims. The Advisory Council also recom-

mends that a directory be published listing the "participating physicians" and that expedited billing incentives be made available to such "participating physicians."

Comment: This proposal has essentially been adopted by the Congress and the AMA has called for elimination of the "participating physician" provisions.

18. Medical technology development.—The Advisory Council recommends that it should be a fundamental policy of the Department of Health and Human Services to promote the development of medical technology. In evaluating new technology, efficacy and cost should be considered.

Comment: The AMA supports the Advisory Council's recommendation.

19. "Advance Directives" or "Living Wills".—The Advisory Council recommends support for the concept of voluntarily advanced directives as a means of appropriate decision-making about life-sustaining treatment for incapacitated patients. The Advisory Council suggests that where states authorize living wills that they be offered to Medicare beneficiaries during sign-up for the program.

Comment: The AMA opposes the Advisory Council's recommendation in principle. Living wills should be used for alleviating suffering and not linked to cost containment objectives.

20. Management of the Medicare program.—The Advisory Council recommends that HCFA continue its efforts to improve the management of the Medicare program.

Comment: The AMA supports the Advisory Council's recommendation.

21. Income-related premiums.—The Advisory Council recommends opposition to any effort to tie entitlement to Medicare benefits to a beneficiary's financial status.

Comment: As noted earlier, the AMA supports modifications to the program that would recognize beneficiary income for certain aspects of the program.

Chairman JACOBS. Dr. Talbott.

STATEMENT OF JOHN A. TALBOTT, M.D., PRESIDENT, AMERICAN PSYCHIATRIC ASSOCIATION

Dr. TALBOTT. Thank you, Mr. Chairman.

I have written testimony to be entered into the record, if you so allow. I would like to make a few comments about the testimony.

I am John Talbott, M.D., professor of psychiatry, Cornell Medical College, and the president of the American Psychiatric Association, an association of 30,000 psychiatrists throughout the country.

We are not only concerned about costs but also about quality of medical care. We are proud that in a recent AMA study, psychiatrists were shown as the specialty that produced the most charity care for the unemployed over the past few years.

The elderly in America, 15 to 25 percent of whom have symptoms of mental illness, are seen very little in its health system. Only 4 percent of patients seen in outpatient care or 2 percent in inpatient care are over 65. And yet, of those labeled "senile," a great number, perhaps as large as a quarter, are actually suffering from mental illness that can be treated and reversed.

Medicare has continued to place an emphasis on short-term acute hospitalization rather than lower cost outpatient alternatives. It continues to cap benefits for outpatient treatment of mental illness at $250 for the Federal share per year.

The result is obvious. Effective outpatient treatment of depression, psychosis, and other treatable conditions is denied at reimbursable levels. The alternative is necessarily more expensive hospitalization.

Just yesterday we released a report on the homeless mentally ill in America, reported in the New York Times and Washington Post. One of the serious questions raised by our current studies is the relationship between capping care for the mentally ill under Medi-

care and how many of such people denied effective care become the homeless on the streets?

There are a lot of data available about cost-benefits of outpatient psychiatric care both in terms of offset medical and surgical costs and enhanced productivity. The offset studies have been presented before this subcommittee previously and include studies done by Blue Cross in western Pennsylvania, Kaiser in California, GHA in the District and in Texas. All show that provision of mental health services reduces the overall cost of other medical and surgical health care.

In terms of productivity, we also know that the introduction of lithium for the treatment of manic-depressive illness in the last 10 years has produced a cost saving of $1.28 billion, and $2.88 billion in direct mental health care.

In the up-coming October issue of the American Journal of Psychiatry, our official journal, there will be a review of 58 controlled studies as well as analyses of the Blue Cross and Blue Shield Federal employee plan from 1974 to 1978. The study shows the average reduction in health care costs is 33 percent through the provision of psychiatric services. The average inpatient-day reduction is 1.5 days. And the study concludes that those over 55 show the most dramatic reduction in costs and days.

A limited psychiatric benefit under Medicare has distinct ramifications in its relationship to prospective pricing strategies. Social policy ramifications of not providing appropriate care of mental illness are great both in terms of cost and in terms of continuing illness and lack of productivity. We very much wish to be competitive in the changing world of health care, but it is very important not to discriminate against physical and mental illness so we may indeed compete equitably.

Both physical and mental illness have severe impacts on American citizens on productivity, economic viability, and life. Their economic and clinical interaction must be understood in any contemplated changes in the Medicare Program.

Thank you very much. I would be delighted to answer any questions the chairman may have.

Chairman JACOBS. Thank you.

[The prepared statement follows:]

STATEMENT OF JOHN A. TALBOTT, M.D., PRESIDENT, AMERICAN PSYCHIATRIC ASSOCIATION

Mr. Chairman and members of the Subcommittee, my name is John A. Talbott, M.D., and I am President of the American Psychiatric Association. I am also Professor of Psychiatry at Cornell University Medical College.

The American Psychiatric Association, a medical specialty society representing over 29,000 psychiatrists nationwide, appreciates this opportunity to testify on issues surrounding the funding crisis confronting the Medicare program as well as proposed legislative and other solutions to this crisis. At the outset, it is important to note that the APA shares Congress' concern with the spiraling cost of both public and private sector health care delivery, particularly in this time of budgetary crisis in the Social Security system and rising national deficits. As does the American Medical Association, we believe that the public and private sectors must seek answers not only to the question of medical care cost but also to the equally pressing question of access to quality medical care. It is incumbent upon us to reconcile both of these issues, without compromising either.

We are particularly proud, for example, that psychiatrists have been in the forefront in providing care to the financially indigent—part of our effort to ensure that

quality care is available without regard to ability to pay. A recent analysis by the American Medical Association Center for Health Policy Research of the provision of charity medical care in 1982 to unemployed patients who lost their health insurance benefits found that "psychiatrists provided more free or reduced fee care to the unemployed than physicians in other specialties." At the same time, increasing numbers of psychiatrists are working with other medically disadvantaged populations—Indians and other native Americans, the elderly, the chronically mentally ill, the homeless—in an effort to ensure that quality health care is available to those least able to help themselves.

Notwithstanding these "pro bono" efforts, and despite both the medical profession and the government wanting an efficient, cost-effective system of quality health care, the costs of health care in general, and Federal health care expenditures more specifically, continue to escalate.

We posit that some of the problem is inherent in the changing demographics of our nation, some inherent in the structure of the Medicare system as it continues to exist—notwithstanding the changes wrought by implementation of the Prospective Payment System—and some inherent in the social policy decision-making which controls Federal health care expenditures (often to the detriment of the delivery of quality health care). I will discuss each of these issues in turn, and comment on current proposed legislative solutions to this funding crisis in health care.

HEALTH CARE COSTS AND THE MEDICARE POPULATION

In 1965, total health care expenditures were approximately $39 billion and represented 5.9 percent of the gross national product. In 1982, those figures had increased to approximately $321 billion, at approximately 10.5 percent of GNP. The Administration's projections indicate that total health care expenditures will exceed $750 billion by 1990, and this will account for around 12 percent of the gross national product.

As was noted in "Health Care Financing Review" (March, 1983), health care costs are not immune to outside market forces, and the rampant inflation which recently beset the nation has contributed to the rise in health care costs. The article noted that general inflation "accounted for approximately 57% of the increase in total systems costs (personal health care costs) for the period of 1971 to 1981."

In addition to general inflation, health care costs—in the instant case, Medicare costs—are also not immune to changes in demographics.

As noted above, health care expenditures and the Federal responsibility for health care insurance through Medicare are sensitive to changing demographics. They will increase over time as the population, and the elderly population in particular, increases. Between 1983 and 2025, the total population is projected to grow by almost 30 percent, with the elderly population doubling to a total of 58 million or 19.4 percent of the total population. Forty percent of the elderly are now over the age of 75, and this figure will increase to 45 percent by 2025. At the same time, the ratio of workers contributing to Medicare through payroll deductions will decrease from five to one in 1990 to 3 to 1 in 2025.

As the population ages, per capita health care expenditures also rise. Although comprising 11 percent of the total population today, the elderly make 30 percent of all patient visits to office-based physicians, and account for 43 percent of all hospital expenditures. In 1978, short-stay hospital admissions for persons age 65 and over were about 350 per thousand population, while for those under age 65, the figure was about 132 per thousand population. Older patients have an average length of stay 76 percent greater than younger patients. The percentage of the population suffering from chronic conditions increases from 8.9 percent in those age 17-44 to 24.1 percent in the 45-64 age group to a staggering 46.4 percent for those over age 65.

Among the elderly is a segment about which we are particularly concerned—and for whom increasing Medicare costs as controlled by many of the proposals before the Subcommittee would be more detrimental than helpful—the mentally ill elderly. I am speaking of the 15 to 25 percent of older persons who have significant symptoms of mental disease. The Subcommittee should recognize that depressive disorders beyond age 65 range at approximately 10 percent of the population; the likelihood of psychosis increases significantly after age 65 and even more so after age 75. Nearly one out of every four suicides is committed by a person age 60 or more. These figures exclude those diagnosed as "senile" and written off as untreatable—when a full 25 percent of such individuals actually are suffering from mental illness which, if properly diagnosed, could be treated and often reversed. (The Subcommittee should be mindful of the health care expenditures associated with such "senile" elderly—nursing home beds, acute care hospital beds, state mental facilities—all

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adding dollars to Medicare costs which otherwise might be saved through early outpatient psychiatric intervention.)

Yet, only four percent of those patients seen in outpatient public and private mental health facilities and two percent seen in inpatient psychiatric settings are over age 65. Medicare payments for inpatient psychiatric treatment represented only 2 percent of the total Part A expenditure, and represented less than one percent of the total Supplemental Medical Insurance (SMI) reimbursement under Part B outpatient physican treatment, substantially below the proportion of the mentally ill elderly in the population. Overall, Medicare covers on the average only 44 percent of the elderly's health care costs, and nearly 66 percent of the elderly supplement Medicare with private insurance to guard against large uncovered charges. Psychiatric intervention—both inpatient and outpatient—ranks high among those uncovered charges, directly as the result of Medicare's limitations of such treatment.

I would like to turn for a moment to the Medicare program, what its benefits represent to the average elderly ill person, and what they represent specifically to the mentally ill elderly.

MEDICARE PROGRAM AND THE MENTALLY ILL

The Medicare program, enacted nearly 20 years ago, continues to place its emphasis on short-term, acute care hospitalization (and I emphasize hospitalization) in lieu of low cost outpatient alternatives to that care. To the extent that the Prospective Payment System encourages some hospital-based activities to be shifted (for better or for worse) to the outpatient sector, then Medicare Part B should be examined carefully for gaps in such less costly outpatient care which hitherto have left no alternative to the medical profession but to hospitalize the patient.

Notable among these gaps is the continued capping of benefits for the outpatient treatment of mental illness to a $250 Federal share, matched by a similar patient copayment. We know that the cost of elderly Medicare beneficiary outpatient charges (reasonable cost per enrollee) has increased more than fourfold since 1967 (up from an average of $103.44 in 1967 to $416.92 in 1981). Yet there has been no recognition of the impact of such increased cost upon the treatment of mental illness. If we were to assume the same increase for the treatment of mental illness over the same 14-year period, the $250 limit is now worth ¼ of what it was in 1967, or $62.50. The outpatient Medicare psychiatric benefit is worth just over one eighth of the costs of the Part A and B deductibles and Part B premiums paid by today's Medicare beneficiaries. That is hardly cost-efficiency. Effective outpatient intervention for depression, psychosis or other treatable, reversible disorders of the elderly is, in effect, denied at such a reimbursement level. The physician's alternative for his or her patient, to date, has been more expensive, not always necessary hospitalization. This alternative may or may not be medically essential. It is a necessity due to medicare law, but it is not cost-efficient.

PSYCHIATRIC INTERVENTION REDUCES OTHER HEALTH CARE COSTS

Some of what I will address may strike a reminiscent chord—since some of our recommendations for legislative action and concerns about existing Federal health insurance programs have been voiced by the APA and its representatives in each of the past four or five Congresses.

As we have articulated before this Committee in the past in far greater detail, it has been widely demonstrated that there is a positive cost benefit to the provision of outpatient psychiatric care, both in terms of offset physical health care costs, and in terms of productivity. In the context of the DRG hospital cost system and its potential diversion of patients from the inpatient to the outpatient setting, the cost-enhancing and medically appropriate benefits are shown in even bolder relief.

These direct cost savings attributable to the availability of a full range of psychiatric treatment have been well documented in study after study. It has been amply demonstrated that coverage of psychiatric disorders actually reduces other health care costs, providing a net cost savings.

Blue Cross of Western Pennsylvania assessed the medical/surgical utilization of a group of subscribers who used a psychotherapy outpatient benefit in community mental health centers with a comparison group of subscribers from whom such services were not made available. The findings showed that the medical/surgical utilization rate was reduced significantly for the group which used the psychiatric benefits. The monthly cost per patient for medical services was more than halved—dropping from $16.47 to $7.06;

Kaiser Plan in California estimated that subsequent savings for each patient receiving psychiatric care were on the order of $250 per year. In a study which matched each of the 152 patients in the study group with a similar person who had a similar level of psychologic distress but who did not seek psychotherapy, the control group experienced virtually no change in health care utilization over the next five years. On the other hand, the study group (the group receiving psychiatric care) reduced its non-psychiatric outpatient visits by 62 percent and its inpatient days by 68 percent;

Group Health Association of Washington has found that patients treated by mental health providers reduced non-psychiatric physician usage by 30.7 percent in the year after referral for mental health care was made available compared to the previous year. Furthermore, laboratory and x-ray services declined by 29.08 percent;

In Texas, a longitudinal study (1973–1977) demonstrated that access to needed treatment for mental illness resulted in a reduction in mean length of stay of over age 65 patients in inpatient facilities from 111 days to 53 days. This halving of hospitalization resulted in a cost reduction of more than $1.1 million.

Further, the introduction of lithium for the treatment of manic depression, over the past decade, has resulted in heightened productivity of those in our workforce suffering from this disorder—saving $1.28 billion in productivity alone during that ten-year span. Further, it has been estimated to have saved $2.88 billion in direct mental health costs.

A study compared 24 elderly patients who had undergone surgery for repair of hip fractures and had liaison psychiatric services with a similar group of 26 patients who had the same kind of surgery but did not receive the liaison services. The group receiving psychiatric liaison care required an average of 12 days less hopsitalization resulting in an estimated savings of $193,000 or almost twenty times the cost of the psychiatric liaison services. Moreover, twice as many patients who had psychiatric liaison services were able to return home (rather than to nursing homes or other less cost-effective institutional settings).

A most recent study, the results of which will be published in the October, 1984, American Journal of Psychiatry, has pointed even more clearly to the specific benefit of increased psychiatric intervention for the Medicare population specifically. Mumford, Schlesinger, Glass, et. al. found that a meta-analysis of 58 controlled studies and analyses of the claims files for the Blue Cross and Blue Shield Federal Employees Plan for 1974–1978 provide mutually supporting evidence of the cost-offset effects of outpatient mental health treatment. Of 26 time-series studies reviewed, the average reduction in other health care costs as the result of psychiatric intervention was approximately 33 percent. Of 22 experimental inpatient studies conducted, it was found that modest psychiatric interventions ("liaison psychiatry") reduced inpatient hospitalizations by approximately 1.5 days below the control groups' average of 8.7 days.

When controlling for age, the researchers found that "in 15 inpatient studies the correlation between the mean age listed in each study and the effect size was −.44 indicating that older subjects benefit more . . . In . . . outpatient studies that used visits to the doctor as the outcome measure . . . the correlation between mean age and effect size was −.31 . . . (Overall) a consistent finding emerges: Older people tend to have greater offset effects following mental health treatment."

In a review of FEHBP data from 1974–1978, the researchers found that "the oldest age group among the mental health treatment persons, those over 55, clearly showed the most dramatic decrease in hospital charges; in 1974 they had average inpatient medical charges more than $160 higher than those of the comparison group. In 1978, they were spending $70 less."

In summary, the researchers noted that "in view of the evidence from the literature and from our studies of health insurance claims, underutilization of mental health services by the elderly may result in needless suffering among the elderly and needless cost to society."

The implications of the limited psychiatric benefit under Medicare are evident as they related to the PPS. They are even more difficult when one seeks to impose a "competition" model on the Medicare program, as proposed in the Kennedy-Gephardt "Medicare Solvency and Health Care Financing Reform Act of 1984." At the risk of repeating testimony presented previously before this Committee, I must note that it is true that people are not clamoring for better psychiatric benefits under Medicare. In part, this is based upon misperceptions about the nature of mental illness and its treatment; in part, on an individual's denial of becoming the victim of mental illness; and in part, it is based upon a stigma—a stigma which we are seeking to help end through such enactments as "Mental Illness Awareness Week," in-

troduced by Congressman Wyden and cosponsored by the Chairman and a number of his colleagues on this Subcommittee.

Since mental illness, as all other illness, more often than not strikes in a random fashion, many of those not suffering now from such an illness are likely not to be thinking about insuring against an illness in the future, particularly when they deny ever falling victim to mental illness despite epidemiological evidence of the incidence of mental illness. People often do not or cannot think about what level of benefits they may require at some point in the future under a particular health plan, and unless they are insured against such an illness, the likelihood of greater costs—both in less appropriate, but insurable care, and in lost productivity—is irrefutable.

PROPOSED SOLUTIONS TO THE MEDICARE CRISIS—IMPLICATIONS FOR THE MENTALLY ILL

With the foregoing as prologue, it becomes critical to turn to the solutions to the current Medicare funding crisis now pending before this Subcommittee—whether proposed by members of Congress or by the Administration—and analyze whether as social policy decisions which will affect the delivery of health care to our nation's citizens, they make sense from both cost containment and quality of care perspectives.

It is clear that Medicare as currently structured engenders high costs, but not necessarily costs related to necessary health care. It has been demonstrated that access to psychiatric care reduces the utilization of other health care dollars. Yet, bias and stigma have engendered a social policy which to date has dictated that psychiatric care is not to be reimbursed equitably or equally with physical health care costs. and social policy has dictated that cost savings in this arena cannot accrue. It is clearly time to change that social policy—whether as codified in the Medicare statute, or negotiated through union-management health care contract negotiations for workers' health care.

The measures before this Subcommittee proposes to solve the Medicare funding crisis in multiple ways: (1) increasing beneficiary cost-sharing and deductibles until a catastrophic trigger is reached for Medicare coverage (the Administration's proposal), thereby raising revenues from the many to benefit those few who actually will reach the catastrophic trigger. (The measure is curiously silent on what out-of-pocket costs would actually trigger the catastrophic payment, and therefore suspect insofar as psychiatric illness-related costs are concerned); (2) creating new competitive models (Kennedy-Gephardt) with unstated benefit package requirements (again suspect from our perspective, since as we have testified before this Committee in the past, we do not believe that competition conceptually allows beneficiaries to safeguard against both anticipated, and more importantly, unanticipated, health care expenditures) which will also require multiple layers of costly regulation and paperwork to implement, perhaps offsetting the very cost-savings intended to be realized (and which, as written, may actually diverge philosophically from the PPS, already in place); (3) providing supplemental coverage through Medicare with added premiums for such supplemental benefits—penalizing those requiring psychiatric care, through the imposition of additional charges, for treatment which has been artifically and unnecessarily restricted under Medicare for nearly 20 years (and penalizing the increasing numbers of elderly suffering from chronic illness through added premiums for Federal health system which has failed to recognize that chronic not acute illness is often the larger problem in the aging population).

Each of these proposals contains major social policy decisions which must be faced by the Congress. However, it is clearly time to recognize that current social policy regarding the mentally ill is damaging both to those suffering from such illness and to the fiscal health of our Federal health care system. The Congress forged social policy decisions regarding the rationing of health care which have worked to the benefit of multiple populations of dangerously ill persons—those suffering from kidney failure, those suffering from liver failure, and most recently, those suffering from Alzheimer's disease. Other authorizing and appropriating Committees in this and the other Congressional body have strongly supported and funded research and training for those who are making major breakthroughs in the etiology of mental illness and in treating these disorders. This Subcommittee's social policy decision-making regarding the funding of Federal health care programs can do no less. It is prudent on both human and economic grounds. It is a cost-efficiency which for too long has been ignored. It can save other Medicare dollars, save Medicaid dollars, save mentally ill elderly from additional insurance burdens, and save Congress from enacting further social policy which in essence refutes the availability of quality medical care for a segment of our nation's citizens.

Chairman JACOBS. Mr. Berman, you stated that hospital cost increases on an annual basis have declined this year to the lowest point. I take it you mean since the Medicare Program started. Is that an absolute figure or is that relative to inflation generally? Have you moved down in relation to inflation generally or the CPI generally?

Mr. BERMAN. For the year ended June 1984, which is our most current data, total inpatient expenses increased 5.2 percent. For that same time period, CPI, all items increased 4.2 percent.

Chairman JACOBS. Thank you.

Are there any additional comments from any members of the panel? The committee expresses its gratitude for your contribution to the record. Thank you. We appreciate your coming in.

Our next panel includes the Health Insurance Association of America, Donald M. Peterson, president and chief operating officer, Benefit Trust Life Insurance Co., accompanied by Mr. James Dorsch, Washington counsel, and Karen Williams, Federal representative; Blue Cross and Blue Shield Association, Mary Lehnhard, vice president; and the Washington Business Group on Health, Willis Goldbeck, president.

The last person I mentioned will be informing and entertaining. So can we proceed in the order in which you were called.

STATEMENT OF DONALD M. PETERSON, PRESIDENT, BENEFIT TRUST LIFE INSURANCE CO., REPRESENTING HEALTH INSURANCE ASSOCIATION OF AMERICA, ACCOMPANIED BY JAMES A. DORSCH, WASHINGTON COUNSEL AND KAREN WILLIAMS, FEDERAL REPRESENTATIVE

Mr. PETERSON. I am Donald Peterson, president, Benefit Trust Life Insurance Co. Today I also represent the Health Insurance Association of America. With me are Karen Williams and James Dorsch of the Washington staff.

I will briefly summarize my statement and then ask that the full text be placed in the record. As CBO witnesses indicated earlier, the trust fund crisis continues despite Medicare's new distributing system. Serious steps must be taken and soon if a rational solution is to be implemented.

We have supported prospective pricing for years, and in this respect commend the passage of prospective pricing for Medicare. The recent change in the way hospitals are paid under Medicare probably would not have been enacted were it not for the persistent rapid increases in health care costs seen in recent years.

However, these increased costs and their effects on Government programs are just as applicable to the insurance coverage purchased by employers for their employees and by individuals for themselves. When Medicare pays less, private payers pay more, in effect, setting up a hidden tax on other hospital patients which we estimate will reach $8.8 billion in 1984.

As a result of this cost shifting to private payers, group health insurance premium rates have been increasing 15 to 30 percent annually. These increases are ultimately shared by employers, employees and consumers and adversely affecting the health of American industry. The Federal Government's role as a catalyst has

helped encourage certain innovation in State or payer cost containment systems. We believe these systems foster competition by legislatively introducing constraints that the free market has failed to provide.

We believe this is the prime role for the Federal Government and should be continued. We commend the Congress for its recognition of qualified State programs as an alternative method of Medicare payment under the Social Security Amendments of 1983 and for your continued interest in seeing that the administration implements necessary provisions.

We ask you now to adopt positive incentives to the States to develop their own qualified programs for all patients. We urge the Congress to take the next step in prospective pricing, to enact legislation extending a hospital prospective pricing system to all payers, not just Medicare, such a system to take effect 4 years after enactment in any State which has not implemented a qualified State program.

This would give every State sufficient time to enact legislation suitable to its own particular needs and yet guarantee that all our citizens get the protection they deserve. Such a proposal need not and should not require any prescribed type of program, rate setting, distributing or otherwise, as long as the State program meets the criteria set forth in the Social Security Amendments of 1983.

It would provide a stimulus to those who believe our problems are best solved at the State level to move ahead and get the job done so there will be no need for a Federal all-payer program.

Another incentive could be a modest Medicaid reward for those States that enact qualified programs similar to the reward in present law for States which had hospital cost containment programs in place on July 1, 1981. This would be an effective way to attack a national problem at the State level without a new Federal bureaucracy. It would be an appropriate reward to those States which, by holding down rising health costs, are taking action to reduce the number of our citizens forced into Medicaid and other public assistance programs by health care inflation.

On the other side of the cost containment coin, Mr. Chairman, the administration has asked Congress to levy a tax on employee health plans. The health insurance industry opposes this proposal as being not only economically unsound and unfair but most significantly as one that will do nothing to stop health care cost inflation. Specifically, it would penalize older workers, those in hazardous occupations, and those in high-cost geographical areas. It would also result in reduced availability of coverage for preventive care services.

A prospective all-payer system, however, will force cost savings incentives into the structure of hospital pricing practices and will have many times the impact of the band-aid approach of taxing workers' health insurance premiums. Clearly, our ideas coincide with many of the concepts expressed in H.R. 4870 introduced by Congressman Gephardt. To that extent, we agree with the more than 50 cosponsors of that bill and applaud the initiative they have taken. All our citizens need relief from rising hospital costs, not just those on Medicare.

We appreciate this opportunity to present our views. We will certainly be glad to work with the committee toward constructive solutions to the difficult problems we all face due to the rising cost of health care.

Thank you.

[The prepared statement follows:]

STATEMENT OF DONALD M. PETERSON, PRESIDENT, BENEFIT TRUST LIFE INSURANCE CO., ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

I am Donald M. Peterson, President of Benefit Trust Life Insurance Company. Today I also represent the Health Insurance Association of America. With me is Karen Williams and James A. Dorsch, of the HIAA Washington staff. The HIAA is a trade association of approximately 325 companies which together write over 85% of the country's commercial health insurance. We appear today on their behalf.

The Medicare trust fund crisis continues despite Medicare's new DRG system. Serious steps must be taken-and soon-if a rational solution is to be enacted.

The recently enacted law serves as a good starting point for discussion of the issues. It changes Medicare's hospital payment for the present retrospective determination of incurred costs to a system of prospectively determined prices. We agree that this change in incentives is highly desirable. In fact, prospective payment may be our last chance for a competitive solution to rising hospital costs. However, the new prospective pricing system applies only to Medicare. Any system that does not apply to all patients will not produce the desired changes in hospital behavior.

The change in payment basis under Medicare would probably not have been enacted were it not for persistent, rapid increases in health care costs in recent years. These increases and their effects on government programs are just as applicable to the insurance coverage purchased by employers for their employees, by individuals for themselves, and by the self-insured. As a result, annual health insurance premiums are still increasing at rates which range from 15% to 30% depending on the size and location of the business. These increases are ultimately shared by the employers, employees and consumers and adversely affect the health of American industry.

A prospective pricing system which applies only to Medicare will admittedly hold down Medicare outlays, but hospitals could simply shift costs to other payers. If the change to a prospective system provides the right incentives to hospitals to voluntarily control health care expenses, and we agree that it does, such a change is equally needed by those who are not eligible for Medicare.

The existence of cost shifting has become well-documented since our industry publicly identified the problem a couple of years ago. Cost shifting totalled $5.8 billion in 1982. According to our lastest estimates, the cost shift will grow to $8.8 billion in 1984.

As a logical business practice, hospitals recoup reductions in Medicare and Medicaid reimbursement by inflating charges to private patients. Those who are insured get higher premiums. Those who are not—such as laid-off workers who have lost their insurance—are faced with a ruinous hidden tax exacted at a time when they are least able to pay—a tax on their already sky-rocketing hospital charges. Without government action on an all-payer system, all private patients remain vulnerable to an unprecedented and financially intolerable level of cost shifting.

In theory, prospective payment leads to cost containment because hospitals will work with physicians to voluntarily reduce length of stay and ancillary services. The incentive for such behavioral changes is profit; hospitals will finally be able to get more money for doing less. But hospitals say such changes take time and substantial effort. In practice, hospitals will find it far easier to cost shift than to cost contain.

We support federal legislation that effectively protects private patients from additional cost shifts. Such protection should take the form of a residual prospective payment system for all-payers. The system would not necessarily require that all-payers initially pay the same price for hospital services. But discounts ought to be justified by savings to the hospital and be available to all patients. For example, discounts for prompt payment would be appropriate. As a practical matter Medicare could receive some special guarantees against program cost increases. Congress has already written into the law such a provision for any state system recognized by Medicare. Under the Social Security Amendments of 1983, if the Secretary of HHS finds that, over any three year period, Medicare has paid more under the state

system than it would have paid otherwise, the Secretary may reduce subsequent Medicare payments to hospitals under that system by that amount.

I would like to shed some light on arguments against an all-payer system. The Administration says that we private insurers will piggyback on the Medicare DRG prices once we recognize that we are paying too much for hospital care. Mr. Chairman, we already know we are paying too much but we are unable to pay less under a combination of current federal policies that generate cost shifting while prohibiting joint negotiation by insurers. We are caught between the competitive forces in the insurance market and the failures in the non-competitive hospital industry. Current comprehensive benefit contracts with employers would prohibit us from limiting our payments to hospitals to the Medicare rate because hospitals would bill employees for the difference. Employers and employees have made a conscious decision to elect comprehensive medical benefits in 90% of our group business.

If, in the future, an individual insurance company only offered to sell plans which limit benefits to the Medicare DRG rates, employers would again exercise their option in the free market to buy comprehensive benefits from another insurance company. What if the federal government intervened in the competitive health insurance market and prohibited the selling of comprehensive medical benefits; would you then indirectly succeed in controlling hospital costs? No, hospitals would charge patients all that the market would bear above the indemnity amounts. Many hospitals would soon find their solvency threatened as bad debts mounted.

You may ask whether we negotiate with hospitals to accept less than their charges as full payment. Hospitals have agreed to such requests to voluntarily reduce their revenues only where an employer or insurer has sufficient volume to force acceptance. Some Blue Cross plans so dominate their local areas as to be successful in obtaining such volume discounts. For the vast majority of the country, however, neither the insurance company nor the employer has sufficient local volume to negotiate charges and thereby prevent cost shifting. To drive home the point, the largest private health insurer in the country has only 4% of the private health insurance market, and that is spread over 50 states. We are too dispersed to negotiate individually and we are prohibited by antitrust laws from negotiating jointly.

A concrete example illustrates the problem. In 1982 Children's Hospital of Philadelphia lost $4,000,000. In the year ending June 30, 1983, this was reduced to $895,000 in the following manner: "(1) we lost $4,354,000 because of inadequate reimbursement for Medicaid services, which is a combined federal and state program, (2) we gained $91,000 from Blue Cross reimbursement, and (3) we made $4,461,000 above cost from the private insurance companies (but we lost $1,093,000 from the self-pay patient services) . . ." (Letter attached.)

Experience validates our frustrations over cost shifting. Experience has also shown that second-opinion surgery, ambulatory benefits and other coverage designed to reduce utilization are successful but alone have limited impact. Finally, experience with State prospective payment systems demonstrates their effectiveness in containing aggregate health care costs.

This is a developing area and no one yet can claim to have all the answers to the questions of a single hospital payment reform system. In fact, two of the oldest and most effective systems, the Maryland and New Jersey programs, operate quite differently. HHS recently granted waivers to New York and Massachusetts, two of the nation's high cost states. In both of these states, all parties with a direct stake in hospital payment change—providers, employers, unions and insurers—actively participated in designing a solution. Both are implementing approaches different from those in Maryland and New Jersey. We believe all of these different approaches will lower costs and produce useful comparisons.

Maine, West Virginia, Connecticut and Washington have also recently enacted all-payer programs which we hope will meet the new criteria for Medicare recognition.

The federal government's past role as a catalyst has helped encourage variety and innovation in state all-payer cost containment systems. We believe these systems foster competition by introducing legislatively constraints that the free market has failed to provide. We believe this is the prime role for the federal government, and should be continued. We commend the Congress for its recognition of qualified state programs as an alternative method of Medicare payment under the Social Security Amendments of 1983 and for your continued interest in seeing that the Administration implements these provisions. We urge you now to adopt positive incentives to States to develop their own qualified programs for all patients.

One such incentive would be a Medicaid reward for those States which enact qualified programs similar to the reward in present law for States which had hospi-

tal cost containment programs in place on July 1, 1981. A modest Medicaid reward would be most appropriate for those States which are moving ahead to help solve a national problem-health cost inflation. It would be a fitting way to attack a national problem at the State level without a new Federal bureaucracy. It would be a fitting reward to those States which, by holding down rising health costs, are taking action to hold down the number of citizens forced into Medicaid and other public assistance programs by health care inflation. Such a proposal need not, and should not, require any particular type of program, rate-setting, DRG, or otherwise, as long as the State program meets the criteria set forth in the Social Security Amendments of 1983.

We further urge the Congress to take the next step on prospective pricing—to enact legislation extending a hospital prospective pricing system to all payers, not just Medicare, to take effect four years after enactment in any State which has not enacted a qualified State program. Such legislation would give every State time to enact legislation suitable to its own particular needs and yet guarantee that all our citizens get the protection they deserve. It would also provide a stimulus to those who believe our problems are best solved at the State level to move ahead and get the job done so there will be no need for a Federal all-payer program.

We also recognize that any over-all solution to the problem of rising health costs requires a reconciliation of the vital interests of a number of important segments of our society. Therefore we continue to support the appointment of a Presidential Commission, upon which all of these interests, providers, insurers, employers, and unions, among others, can be represented and which can be charged with the constructive resolution of the conflicts which make this program so intractable.

Another improvement would be to require Medicare participating hospitals to allocate equally among all private patients that portion of their budgets not reimbursed by Medicare or Medicaid.

ADVISORY COUNCIL PROPOSAL FOR MEDICARE SUPPLEMENTAL COVERAGE

One proposal of the Advisory Council on Social Security suggests extending Part A to cover all hospital days, the adoption of coinsurance during the first 60 days, placing a $200 out-of-pocket limit on Part B expenses and the elimination of Part B benefits if insureds don't purchase coverage supplementing the Part A coinsurance amounts. The premium charged to Medicare eligibles would be increased dramatically.

There are a number of problems with this approach. First, the choice of purchasing coverage supplementing Part A vs. losing Part B benefits is inappropriate.

Second, the dramatic increase in premium may be beyond the economic means of many retired citizens and thus deny them their current Part B benefits.

Third, the supplemental insurance option could falsely lead the elderly into believing that private insurance is unnecessary even though Medicare would still not cover a large share of their medical expenses.

Fourth, the premise of their proposal that private supplemental insurance is confusing and duplicative is invalid. Federal standards enacted by the Congress have already addressed that issue.

Fifth, the viability of private supplemental insurance would be reduced which would adversely affect the public service work of insurance agents in explaining the Medicare program.

Proposals to revise the benefits, eligibility, deductibles, co-payments and premiums all involve a re-shuffling of who pays the medical bills for the over-65 population rather than attempting to overtly reduce the size of the nation's medical bill itself. The Health Insurance Association of America strongly supports instead measures designed to reduce, or at least slow the rate of increase of, the cost of health care for all Americans.

ADVISORY COUNCIL PROPOSAL TO TAX EMPLOYEE HEALTH PLANS

The Advisory Council on Social Security has also endorsed the Administration's proposal to levy a tax on employee health plans as part of its F.Y. 1985 legislative program.

The health insurance industry opposes this proposal as both poor health policy and poor tax policy. Furthermore, a recent independent study by Price Waterhouse raises serious questions about the assumptions upon which the claimed revenue gains are based.

Among the arguments against such a tax are as follows:

It penalizes older workers.—Elderly groups tend to use health care more frequently than younger, healthier workers. Hence, the cost of health insurance for a group

which includes more than the average number of older workers not only will be higher but could discourage many employers from hiring the older worker. Under the Administration proposal, these groups will be adversely affected by a cap, while younger groups with similar coverage may not be taxed.

It penalized those in hazardous, high-risk occupations.—Some groups, such as iron workers or coal miners, are usually considered a higher "risk," and are typically charged higher health insurance premiums. These groups could be unfairly taxed while other groups with similar coverage—such as clerical workers—would be unaffected.

It is a form of "double taxation."—The Health Insurance Association of America estimates that Medicare and Medicaid payment practices will result in $8.8 billion being shifted to patients covered by private health insurance in 1984 to make up for government underpayments to hospitals. For the government to shift these costs to the private sector and then put a tax on the resulting higher insurance premiums is patently unfair.

It unfairly affects certain geographic areas.—The cost of health care is higher in some areas, such as large metropolitan cities. A single national tax cap does not take geographic differences into account, and thus would particularly penalize those in high-cost areas. Conversely, it would allow the tax-free purchase of much more generous benefit plans by those in low-cost areas.

It would result in reduced coverage for preventive care services.—As employees scramble to reduce their overall premium rates, essential preventive care services such as dental care, vision care, mental health benefits, and alcohol and drug abuse services may be dropped from benefit plans. Dropping these benefits does nothing to reduce hospital costs, and in the end may have the opposite effect.

Several recent studies confirm these conclusions. The Rand Corporation study on health care costs published in November 1982 stated that, while the increased cost of employee health insurance resulting form the tax would reduce the over-all amount of health protection available, "Dental care, ambulatory care, drugs, and similar services would probably become uncovered . . . hospital insurance would probably be least changed." Yet it is hospital costs, which constitute more than two-thirds of Medicare's expenses, which are the major problem.

The Rand study also points out that while taxing employees could reduce hospital utilization, the hospitals could recoup the major portion of any lost revenues by raising prices charged the remaining patients. The study concludes, "Effects on consumers' health status are as yet unknown."

A 1983 paper by Gail Wilensky of the National Center for Health Services Research, also concludes that "the proposed change in tax policy will have little effect on expenditures for hospital care, routine physician visits," etc.

Studies and data presented to the Senate Finance Committee in June 1983 by the Employee Benefit Research Institute are also pertinent. Contrary to the conventional belief that employer plans have simply absorbed the inflation in health care costs, their paper states that real employer contributions to health insurance as a share of compensation fell at an annual rate of nearly 8 percent.

EBRI also points out that "Among households that would be affected . . . the tax burden would be severely regressive. As a proportion of income, persons at the lowest level of income (those reporting less than $10,000) would pay more then six times the amount of the additional tax than wouuld persons with income over $50,000."

In studying the impact on the rate of health insurance coverage, the study concludes "Current tax policy probably raises private coverage rates significantly among lower-income worker households, households with fragmented employment histories, younger households, and both single-person and single parent households."

Mr. Chairman, all of those in the private sector who have the most to gain from effective hospital cost containment—the employers, the unions, the insurers—in essence, all of those in the private sector on the paying side of the equation—say the employee health tax will be ineffective in curbing rising costs and are opposed to its enactment. Attached to this statement is a resolution endorsed by some of those groups who wish to be recorded in opposition.

It is a fact that the medical expense people fear most is hospital expense, and it is hospitalization insurance that will be the last, and least, effected by this proposal.

In summary, the most sensible approach to keeping hospital costs under control is prospective payment reform that applies to all patients, not just Medicare patients. Rising costs are not just a Medicare-Medicaid problem but a national health care problem as well. A prospective all-payer system will force cost-saving incentives into the structure of hospital payments operations and will have many times the impact of the band-aid approach of taxing worker's health insurance premiums.

We are beginning to see that prospective payment systems that include all-payers, including Medicare, now in place in four states, can work. There is no reason why the Congress should try the untested theory of taxing health insurance premiums—and every reason why it should not.

The health insurance business shares with this committee a strong commitment to cost containment. It is a strong supporter of state prospective pricing systems which meet the criteria laid down in the Social Security Amendments of 1983.

We do not believe the Congress should mandate any particular kind of system, either rate review or DRG or any other to the states in order to have a qualified program.

The HIAA does feel, however, that positive incentives should be enacted by the Congress to encourage the states to develop their own qualifed programs. This could take the form of a Medicaid reward for enacting a program meeting the standards established in the Social Security Amendments of 1983.

We also recommend Federal legislation which would give the state four years to act, after which the Federal prospective pricing system would apply in any State which had not enacted its own qualified program.

Clearly these ideas coincide with many of the concepts expressed in H.R. 4870, introduced by Congressman Gephardt. To that extent we agree with the more than 50 co-sponsors of that bill and applaud the initiative they have taken. All our citizens need relief from rising hospital costs, not just Medicare.

We appreciate this opportunity to present our views. We will certainly be glad to work with the committee for constructive solutions to the difficult problems facing us all with the rising cost of health care.

Whereas a tax on employee health benefit plans would be discriminatory and unfair in application and ineffective as a means of slowing the rising cost of hospital care, we urge the Congress to REJECT any tax on employee health benefits.

Health Insurance Association of America.
Blue Cross/Blue Shield Associations.
Group Health Association of America.
Laborers International Unions of North America, AFL–CIO.
Caterpillar Tractor Co.
Family Health Program (FHP, Inc.).
Association of Private Pensions and Welfare Plans.
Professional Insurance Agents.
New York Life Insurance Co.
Aetna Life and Casualty.
Insurance Association of Connecticut.
Society of Professional Benefit Administrators.
American Dental Trade Association.
National Association of Private Psychiatric Hospitals.
American Council of Life Insurance.
The Travelers Insurance Co.
American American Optometric Association.
American Psychiatric Association.
American Federation of Teachers/ Federation of Nurses and Health Professionals.
National Education Association.
National Association of Independent Insurers.
National Employee Benefits Institute.
U.S. Chamber of Commerce.
American Dental Association.
National Association of Casualty and Surety Agents.
International Association of Machinists and Aerospace Workers.
Health Resources Corp. of America.
Small Business Council of America, Inc.
International Brotherhood of Teamsters.
CIGNA.
Transamerica Occidental Life Insurance Co.
American Dental Hygienists' Association.
Kemper Group.
Independent Insurance Agents of America.
Peoples Life Insurance Co.
Delta Dental Plans Association.
Alliance of American Insurers.
American Speech-Language-Hearing Association.
National Association of Insurance Brokers.
National Association of Life Underwriters.
American Retail Federation.
National Mental Health Association.
American Hotel and Motel Association.
Health Security Action Council.
Small Business United.

THE CHILDREN'S HOSPITAL OF PHILADELPHIA,
Philadelphia, PA, July 18, 1984.

Senator ARLEN SPECTER,
Hart Senate Office Building,
Washington, DC.

DEAR SENATOR SPECTER: During the June 26th hearing before the Committee on the Judiciary you made a request of me. You asked how much money we lose from the federal government, how much we made up or lost from Blue Cross (specifically as opposed to the generalization about breaking even), how much we profit from pri-

vate insurance companies and how much we picked up on the deficit from other sources.

Here are the answers for the year ending June 30, 1983. (Our statistics for this year are not yet complete.): (1) We lost $4,354,000 because of inadequate reimbursement for Medicaid services, which is a combined federal and state program, (2) we gained $91,000 from Blue Cross reimbursement; (3) we made $4,461,000 above cost from the private insurance companies (but we lost $1,093,000 from the self-pay patient services), and (4) we had a total operating loss of $895,000, a huge improvement over fiscal year 1982 when we lost $4,000,000.

We were able to raise $1,670,000 in unrestricted contributions and $2,300,000 in dividends and interest in endowments.

We have been able to hold down expenses, increase our charges and improve our medical information system to better capture our financial information. These facts plus the improvement in the investment picture have enabled us to compensate for some of the inadequacies in reimbursement.

I would remind you that our costs are exceedingly high because children's hospitals, particularly one like ours with more than 40 percent of its beds allocated to tertiary (intensive and specialized) care are labor-intensive. In addition, most young families cannot afford the bills resulting from the problems that accompany critical illnesses.

I want to thank you for the opportunity to testify against S. 2051—the Health Cost Containment Act. I appreciated having my views heard.

Sincerely,

NOEL E. KRONCKE, *President.*

Chairman JACOBS. Actually, we welcome Mary Nell back to the committee.

STATEMENT OF MARY NELL LEHNHARD, VICE PRESIDENT, BLUE CROSS & BLUE SHIELD ASSOCIATION

Ms. LEHNHARD. Thank you, Mr. Chairman, Mr. Duncan. We are pleased to have the opportunity to comment on two proposed solutions for solving Medicare's deficit, the Medicare Solvency and Health Care Financing Reform Act sponsored by Mr. Gephardt and Senator Kennedy, and the recommendations of the Advisory Council on Social Security.

First, I will comment on the Kennedy-Gephardt bill. A major, though not single, purpose of the Kennedy-Gephardt bill is to assure solvency of the Medicare Program. The intent of the proposal is to achieve this by reducing all health care costs sufficiently to bring the trust fund into balance.

We recognize fully that a reduction in general health care costs would be the most desirable way to solve the trust fund problem. We don't, however, think it is realistic to expect that moderation in health care costs, by itself, would be sufficient to offset Medicare's enormous pending deficit as the Kennedy-Gephardt bill proposes.

We also believe strongly that the regulatory approach, rate setting, to controlling health care prices under the bill would not have a salutary effect on health care costs. We believe that it would rather bring to a halt those current activities that for the first time are resulting in genuine incentives to reduce prices, curb use and eliminate excess capacity.

We recognize that under the proposal States would be given an opportunity to establish any type of program they wanted as an alternative to the Federal program. The incentives, however, and requirements in the bill are such that States would inevitably be pushed toward a State rate-setting program.

Our testimony spells out more fully our concerns about hospital rate setting, and I will highlight briefly some of our points made in

the testimony. First, rate setting is likely to impede cost containing innovations underway in today's marketplace.

Second, we believe that rate setting would let too many of the participants off the hook and avoid the responsibilities of cost containment. Hospital rate regulation would destroy the powerful incentives that Blue Cross and Blue Shield plans and employers of all sizes, unions, and other employers, have to search for cost-effective means of providing care. The major accountability for cost containment would be shifted to a regulatory agency.

Third, the regulation which results from hospital rate setting would do nothing to prevent the practice of so-called cost shifting. The most major part of the so-called cost shift is bad debts. Hospital rate-setting programs generally address the bad debt problem by merely distributing it among those who do pay, primarily employers who provide health benefits. We believe the automatic and mandatory allocation of hospital debt to insurers and ultimately employers is one of the most major public policy steps in the legislation and should be debated thoroughly.

Fourth, it is premature, we believe, and possibly unfeasible to include physician payment as part of the DRG price. We support the objective of constraining physician price and use; however, it seems premature to embark on another major change when the results of the change in the hospital reimbursement are just now being observed.

I would like to also briefly comment on two recommendations of the Advisory Committee. The Advisory Council recommended the imposition of a ceiling on the amount of tax-free employer-provided health benefits. This recommendation, most frequently referred to as the tax cap, has been discussed in a number of forums. We strongly believe that it would be both bad tax policy and bad health policy.

A major concern is the fact that a tax cap would, in effect, impose a sick tax on older and chronically ill workers and on their employers. The employees of companies with a relatively high percentage of older and sick workers would have to pay much more in taxes than workers of other companies.

The Council has also supported a restructured Medicare Program intended to subsidize the hospital insurance trust fund and provide catastrophic coverage primarily through increased premiums.

We question the wisdom of requiring additional out-of-pocket premium payments for expanded coverage at this time. It seems perhaps inappropriate to expand coverage when beneficiaries may be asked to take benefit cuts or premium increases to contribute to the solving of the trust fund financing crisis. In addition, some beneficiaries may not be able to afford the increase in premiums that would be required to obtain protection under this proposal.

Thank you.

[The prepared statement follows:]

STATEMENT OF MARY NELL LEHNHARD, VICE PRESIDENT, BLUE CROSS & BLUE SHIELD ASSOCIATION

Mr. Chairman and Members of the Committee I am Mary Nell Lehnhard, Vice President of Government Relations for the Blue Cross and Blue Shield Association, the national coordinating organization for all Blue Cross and Blue Shield Plans.

Blue Cross and Blue Shield Plans serve more than 80 million Americans in our private business and an additional 20 million individuals through our activities as intermediary or carrier for federal and state health care financing programs.

We believe that finding a solution to the Medicare financing problem is one of the most important and difficult problems before the Congress. Your Committee readily accepted the responsibility of dealing with the financing problem, beginning with the Conference on the Future of Medicare last November. This hearing demonstrates your continuing commitment to examine and allow public comment on all possible solutions. We welcome the opportunity to comment on two proposed solutions for alleviating Medicare's future deficit under consideration today: (1) the "Medicare Solvency and Health Care Financing Reform Act of 1984," sponsored by Representatives Gephardt and Senator Kennedy; and 2) recommendations of the Advisory Council on Social Security.

THE MEDICARE SOLVENCY AND HEALTH CARE FINANCING REFORM ACT OF 1984

A major, although not the single, purpose of the Kennedy/Gephardt bill is to assure the solvency of the Medicare program. The intent of the proposal is to achieve this by reducing all health care costs sufficiently to bring the Medicare Hospital Insurance Trust Fund into balance.

We recognize that a reduction in general health care costs represents the most desirable way to solve Medicare's major problem. It avoids difficult and painful decisions on whether to increase trust fund revenues through general revenues or higher taxes, or reduce Medicare expenditures through changes in eligibility, program coverage or patient cost sharing.

We believe, in fact, that the health care marketplace is undergoing some major changes that are having a truly significant affect on costs, and that the hoped for reduction in general health care costs is already occuring. The competitive forces unleashed in the last two years are beginning to reduce prices, curb utilization and, importantly, eliminate unnecessary capacity. The marketplace has been driven into this competitive mode primarily by employers insisting that their employee health benefit costs be curbed and by Medicare's dramatic move to being a prudent purchaser. This moderation in prices and utilization, for the first time, has allowed a number of Blue Cross and Blue Shield Plans to provide premium refunds to subscribers.

We do not, however, believe that it is realistic to expect that moderation in health care costs generally will be sufficient to offset Medicare's enormous pending deficit. We estimate that to balance trust fund income against outgo through 1995 entirely by reducing hospital price per admission, the DRG limits would have to be set at market basket minus 2.8 percent each year on average.

We also believe strongly that the regulatory approach—rate-setting—to controlling hospital prices under the Kennedy/Gephardt bill would not have a salutary effect on health care costs but rather would bring to a halt those current activities that, for the first time, are resulting in fundamental changes in our financing and delivery systems.

We recognize that, under the proposal, states would be given the opportunity to establish any type of cost containment program as an alternative to the federal program. Such plans must meet federal standards. However, the incentives and the requirements are such that states inevitably would be pushed towards rate-setting programs.

I would like to elaborate on why we do not believe that a rate-setting approach—under a universal federal or state-designed program--would resolve the basic problems involved in containing the cost of health care.

Rate-setting is likely to impede the cost containing innovations underway in today's health care financing marketplace.—Comprehensive hospital rate-setting inhibits and often precludes the cost containing innovations that have begun to multiply rapidly in today's health care financing marketplace. The concepts of prudent buying and selective contracting are increasingly accepted and the Medicare prospective payment system will spark other price-driven systems. These developments are already stimulating changes in the relationships of hospital to physician and payer to provider. Importantly, they are providing the key incentive to reduce excess capacity. Major purchasers are "shopping" and negotiating on behalf of their subscribers and hospitals can no longer carry the cost of their excess capacity and be competitive. Rate regulation, because it is generally premised on the guarantee that the full financial requirements of hospitals will be met, would not address excess capacity without yet another regulatory—and political—framework. With a

competitive dynamic unfolding, now is not the time to freeze health care institutions in their current position—as governmental regulation must inevitably do.

Rate-setting would let many participants in the industry avoid their responsibilities for health care cost containment.—The introduction of hospital rate regulation would destroy the powerful incentives that Blue Cross and Blue Shield Plans, employers of all sizes, unions, and insurers now have to search for more cost-effective means of providing health care. Competition is currently fueling the development of new alternative delivery systems which can deliver quality care at a low price. The major responsibility and accountability for "cost containment" should not be shifted to a regulatory agency of government or to individual subscribers through high cost sharing. We believe that the marketplace forces can and will do the job more creatively and effectively than any governmental program.

Rate-setting would not eliminate the practice described as "cost shifting" but in fact, would institutionalize it.—The regulation which results from hospital rate-setting would do nothing to prevent the practice of so-called "cost shifting" and, indeed, would institutionalize such practices in ways which are often not fully understood.

In the last few years, the commercial insurance industry has conducted a nationwide campaign against "cost shifting." The campaign is designed to foster the establishment of rate setting, or all-payer, systems to preclude third party payers from negotiating to pay less than what a hospital decides to charge for services. Indeed, a "cost shift" is more accurately described as a differential in what purchasers of health care pay for services. The differential arises primarily from the fact that some purchasers negotiate payment rates with hospitals (or, in the case of the government, simply offer specified payment terms). Generally, the negotiations revolve around identifying whether the costs incurred by the hospital, or their charges, are reasonable and relate to the service provided to the subscribers. Payers that negotiate include Blue Cross and Blue Shield Plans, HMOs, PPAs, and some commerical insurers through their own HMOs or PPAs. Other payers, however, pay what a hospital charges for services. The major additional adjustments which may be included in their charges generally fall into two categories: (1) costs that are inappropriate or unnecessary; and (2) lost revenue such as the hospital's bad debts.

Rate-setting programs do not assure that the amount an insurer pays is related to the cost of the services actually provided to its subscribers and that the amount an insurer pays is related to the efficient operation of the hospital. Payments to hospitals under rate-setting programs are frequently established by updating cost incurred by hospitals in a base year, regardless of the appropriateness of these costs.

The other general category of costs—bad debts—results from treatment of patients with no insurance, or those with inadequate insurance who cannot or will not pay the out-of-pocket amounts owed the hospital. Rate-setting programs generally address the bad debt problem by merely distributing it among those who do pay—primarily employers who provide health benefits to their employees—the financial burden of the underinsured and the uninsured, who fail to meet their obligations. This is, in fact, mandated under the Kennedy/Gephardt bill. We believe that the automatic and mandatory allocation of hospital bad debt to insurers—and ultimately to employers is one of the major public policy steps in the legislation. Under existing rate-setting programs, it is not until employers realize that they may be responsible for financing a state reduction in Medicaid benefits or subsidizing hospital-based community programs that they understand the full effect of the new program. Also, such treatment of bad debts under rate setting programs can reduce significantly the hospital's incentive to pursue collection of bad debts and can reduce the federal and state government's incentives to maintain benefit, eligibility, and payment levels in their programs.

Such regulation is based on very limited empirical evidence that total regulation has a significant effect on prices, and no evidence that it provides major incentives to restructure the delivery of care.—Effective, long term cost containment requires a set of incentives that will promote more efficiency and cost effectiveness in the delivery of health care and, importantly, will lead to reduction in excess capacity. In our experience, and in the view of many experts on this subject, the rate-setting programs already in operation do not in fact create such incentives. Rate regulation does appear to create incentives to outmaneuver the system, to match accountant for accountant and lawyer for lawyer. In our view, a more productive set incentives would flow from a price-competitive marketplace. In addition, I would emphasize that research on the current regulatory program is very clear on one finding: such programs do not produce rapid results. We believe that marketplace dynamics now evolving will move more swiftly than any regulatory alternative.

It would disrupt the evolution of the government's role in health care financing.—Finally, to intervene at this point in the evolution of the government's role in health care financing is premature. The federal government is becoming a more prudent purchaser as evidenced by implementation of Medicare's prospective payment system. The impact of this on provider behavior is already producing results every bit as dramatic as those that developed in the mid-1960s when federal and state governments began the commitment to finance medical care for the elderly and poor. We understand and support that evolution and urge that this newest step be given an opportunity to take complete effect. There are strong indications it is indeed working as intended and forcing all segments of the health care system to reexamine their performance in the marketplace.

In addition to our concerns about hospital rate-setting generally, we have the following specific concerns about the provisions of H.R. 4870:

Competitive solutions won't be given a fair chance under H.R. 4870.—Once the government puts itself in the position of measuring the performance of states, it is inevitable that it must "regulate" by defining its method of measurement. The government defines the unit of measurement—in this case revenues per discharge and total revenues—and defines what is in the measurement base—the base year—and what is not. Exceptions and adjustments are defined. Finally, as is almost inevitable, major public decisions are made even for states which "develop their own programs" by spelling out what must be included in their program, for example, and full payment for hospital bad debts.

This is not allowing the marketplace a fair chance nor is it allowing the states to design their own programs.

H.R. 4870 may increase costs rather than contain them.—The focus of H.R. 4870 is on hospital services. The bill assumes that hospital administrators are passive and will continue to conduct business as they always have regardless of any changes in payment. It is difficult to speculate on the response that will occur, however, our early experience with Medicare's prospective payment system (PPS) is instructive. The unbundling of hospital services into non-regulated settings has already begun under PPS and is a likely outcome of measures like H.R. 4870. Hospital administrators may shelter many of their hospital's services from regulatory oversight through corporate reorganization and redesign. Radiology, pathology, laboratory services, and emergency room services all may be broken out from the hospital and established as free-standing wholly-owned subsidiaries. The all-payer system that would ultimately be imposed might be able to rein in inflation in the hospital industry, but it would be a hollow achievement. Hospitals would have sheltered or split away most of their revenues only leaving a small set of services subject to all-payer scrutiny. We suggest that the result of this would be unconstrained price inflation for the unbundled services. Ultimately, systemwide health care costs would increase as hospitals undertake complex and complicated corporate restructurings.

It is premature and possibly infeasible to include physician payment as part of the DRG price.—We support the objective of constraining physician price inflation. However, it seems to us that it would be premature to embark on such a major system change when the first results of the new Medicare system are just being observed. The dynamism of the competitive forces at work in the private sector are yielding returns and the prospective payment system has brought about significant changes in the hospital sector. Wholesale change seems particularly unnecessary now.

Before embracing a DRG-based approach, however, we need to know the answer to questions, such as: whether physician DRGs are necessary to alter physician behavior, and whether they are medically appropriate for physician reimbursement?

RECOMMENDATIONS OF THE ADVISORY COUNCIL ON SOCIAL SECURITY

Other proposals to reform and finance Medicare have been put forth by the Advisory Council on Social Security. The Advisory Council on Social Security worked long and hard to array possible solutions to Medicare's financial problems. We believe that most of these recommendations are worthy of close study by the Congress. As the Council has noted, however, all of the potential policy changes recommended have some drawbacks. I would like to comment specifically on two recommendations made by the Council where we believe the drawbacks far outweigh the potential advantages.

The Advisory Council recommended the imposition of a ceiling on the amount of tax free employer-provider health benefits. This recommendation, most frequently referred to as the "tax cap", has been discussed in a number of forums. We strongly believe that it would be both bad tax policy and bad health policy.

Among our concerns is the fact that a tax cap would, in effect, impose a sick tax on older and chronically ill workers, and on their emloyers. Because older and chronically ill workers tend to use more health benefits, the cost of providing health benefits to a group in which these workers are heavily represented will be higher than the cost of health benefits for a group of young healthy workers. Consequently, if a cap were imposed on the amount of employer-provider benefits, or for that matter if all of the health benefits were taxed, employees of companies with a relatively high percentage of older and chronically ill workers would have to pay more taxes than workers of other companies.

Furthermore, we do not believe that a tax cap is the right way to contain health care costs. As I have mentioned earlier in my testimony, new ways of addressing the cost problem are emerging in a free and competitive marketplace. The sophistication of purchasers of health care will continue to grow, and as it does so will the demand for more effective care. This kind of behavior change, and not an arbitrary move such as the tax cap, is in our opinion, the best way to save health care dollars.

The Council has also supported a restructured Medicare program intended to subsidize the Hospital Insurance Trust Fund, and to provide catastrophic coverage financed primarily through increased Part B premiums. As we understand the Council's proposal, it would provide unlimited hospital inpatient days with three percent per day coinsurance and two admission deductibles per year. In addition, there would be additional Part B benefits to cover the Part A coinsurance and all Part B cost sharing above $200. Skilled nursing facility coinsurance also would be covered. The new coverage would be financed by substantially increased beneficiary premiums. We believe such a recommendation is ill-advised for the following reasons:

We question the wisdom of requiring additional out-of-pocket premium payments for expanded coverage at this time.—It seems inappropriate to us to expand Medicare coverage when we are so near the financial breakpoint of the program. In particular, it is questionable as to whether beneficiaries should be required to finance this expanded coverage when it soon may be necessary to ask them to accept more benefit cuts or additional premium payments, or both, to help contribute to the financial solvency of the Part A Trust Fund. The cumulative financial effect on beneficiaries of automatic increases in current out-of-pocket payments (premiums and cost-sharing), the proposed new Part B premium, and any increased costs resulting from addressing the financial shortfall may prove more than many beneficiaries can afford. If so, their access to the program or their access to care, or both, will be jeopardized.

Some beneficiaries may not be able to afford the significant increase in premiums that would be required to obtain basic Part B protection.—We are extremely concerned about the effect of the restructuring proposal and its immediate attendant cost on Medicare beneficiaries. Currently about 60 percent of Medicare beneficiaries purchase Medigap coverage, while about 15 percent are covered by Medicaid. About 25 percent, mostly low and middle income beneficiares, have no coverage beyond the Medicare program and are not eligible for Medicaid. Although the increase in the premium which would be required by this proposal may seem modest to many, for those aged who are entirely dependent on their Social Security check for living expenses, the increase may represent a major trade-off of other necessities.

A recent HCFA-SRI, Inc. study has shown that most individuals who don't purchase Medigap policies make this choice because they cannot afford to purchase the insurance. If these beneficiaries cannot afford any private Medigap coverage now, they also may not be able to afford the cost of the restructured Part B program; the costs are roughly in the same neighborhood. These beneficiaries would be left with only their entitlement to Part A protection—protection which would have been modified to require extremely heavy up-front patient cost-sharing. This change in cost-sharing—without any fill-in protection—would undoubtedly create a financial barrier to access for those beneficiaries.

Incompatibility with DRG Payment System.—We would also like to add a point relating to the impact of the three percent coinsurance on beneficiaries, providers, and the Medicare program. We believe that the use of per day copayments for hospital services is incompatible with the new DRG system. Under the DRG system, the payment rate to a hospital generally is the same regardless of the length of the hospital stay. Since this provides strong incentives for hospitals to reduce length of stay, increasing the program emphasis on a per day hospital copayment seems inappropriate. We assume that the Council intends that all beneficiaries entitled to Part A will elect the new Part B coverage, and, therefore, never have to pay the three percent copayment. Even if this were true (which we doubt), by restructuring Part A to include a three percent copayment that will not be applied, you would confuse providers and beneficiaries.

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The problems with private Medigap insurance that the Council perceives are being addressed effectively by federal and state Medigap legislation and efforts of insurers.—It appears clear to us that the Council made its catastrophic proposal assuming that the purchase of Medigap insurance is not only confusing to vulnerable beneficiaries, but also an unnecessarily expensive undertaking. We cannot agree.

Recent congressionally-mandated studies have clearly shown that Medigap insurance may be better understood than the Medicare program itself and furthermore, intensive state efforts, such as Buyers Guides and stiff penalties for misleading sales practices, are working successfully to eliminate the problems cited by the Council.

With respect to the cost of Medigap policies, our experience shows that the premium rates vary greatly, depending on the extent of coverage, the area of the country and state regulatory environment. In a 1982 survey of Blue Cross and Blue Shield Plans' Medigap programs, the lowest rate for a program covering minimum benefits was $101 a year. The highest rate listed for a policy with extremely comprehensive coverage was $1,174 a year. However, the vast majority of our policies fall in the $240–420 a year range. Many Blue Cross and Blue Shield Plans sell more than one program, thus affording the Medicare beneficiary a choice between more extensive coverage at higher rates or lesser coverage at lower rates. For example, the Blue Cross and Blue Shield Plan with the $101 a year program also sells programs ranging from $222 to $619. The Plan with the $1,174 program also sells a less comprehensive plan for $328 a year.

CONCLUSION

In summary, the Congress has before it a most difficult and complex task. As you continue your deliberations, we do not believe that it would be realistic for you to assume that the entire Medicare solvency problem can be alleviated by reducing the cost of health care in general. Major reductions in health care costs should be an objective for all of us and could make a substantial contribution to the financing problem. However, the best hope for significant reductions in prices, utilization and excess capacity are to be found, not in the complex regulatory approach in the Kennedy/Gephardt bill, but in the dynamics of the vigorously emerging marketplace. A regulatory program would only suffocate these new and strong incentives.

With respect to the recommendations of the Advisory Council on Social Security, we strongly oppose using a tax on employee health benefits to finance the Medicare program, and we question whether enhancing the Medicare benefit structure is prudent at a time when we are looking for ways to assure its long term survival.

There will be no easy choices, but it is vitually important that we continue to discuss and debate potential reforms. We look forward to the exchange and gladly offer our assistance to the Committee.

Chairman JACOBS. Mr. Goldbeck.

STATEMENT OF WILLIS B. GOLDBECK, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH

Mr. GOLDBECK. Thank you, Mr. Chairman.

I am Willis Goldbeck, president of the Washington Business on Health, and I would like to urge the committee to adopt an approach that you might call prospective policymaking rather than retrospective fixing for this entire area.

We desperately need to take into consideration that our health policies in the past couple of decades have been one series of attempts after another to catchup with the demographic trends, not to meet predicted changes, to catch up with new technological developments, not to foresee them.

This problem is continuing along, and I think one of the greatest things we need to do is to take a very serious look at the configuration of the population that is going to be using the benefits and then come up with the model that will fit their real needs in the 1990's, not just trying to solve the cost problem of the mid 1980's.

Certainly we would agree with several other witnesses' points, that the progress achieved to date has not been adequate. It is far

better than 3 or 4 years ago, but clearly not adequate and certainly nothing that would warrant any Federal official suggesting that the problem has gone away.

It is interesting to note that we are witnessing organizational decentralization in many aspects of the delivery system, certainly in the way care is purchased, the shift from general insurance policies to negotiated care, from single hospital approaches to alternative delivery systems, the development of the local business groups on health, various state innovations, but at the same time technological developments and information systems necessary for any cost management in either the public or private sector are increasingly centralized. So you have a convergence of decentralized organizations and increasingly centralized management and information systems.

It is also important to keep in mind that many of the solutions, so to speak, to the problems of Medicare financing are not going to be found simply within the Medicare system. Medicare is not designed and will never be financed to support 30- and 40-year retirement periods. More and more corporations that 10 years ago, when we started the business group, had an active work force where they were covering 10 and 12 workers for every covered retiree now have one active worker for every covered retiree. There is not a work force there to generate revenues for 30 years of retirement for Medicare benefits.

Some of the problem has to be resolved by the restructuring of the way we treat work, leisure, education and its cycles. I realize that goes beyond the basic purview of any of the pieces of legislation, but I think it is important to point out that there is no one piece of legislation on health care, medical care financing, alone that will resolve the panorama of the change of demographics and all that implies for this society.

We will not resolve the problems of Medicare entirely from the financing standpoint until we make an investment in prevention for the elderly. We have let a concept continue to be held that it is too late for the elderly. Well, perhaps one could stand by that concept if Medicare financed care for people who were going to live a very few more years. But, again, people who are 65 are living into their eighties and increasingly into their nineties, and now we have some 30,000 Americans over the age of 100 in Medicare.

Prevention is not to late for that. There is good factual evidence of impact of prevention on older Americans. It has to be paid for and brought into the system, not considered a second-class add-on.

Finally, as a guiding principle, you might say, we really know now what to do. Cost management is not a mystery. The change in economic incentives is not a mystery. Federal policy must be supportive of cost management, and when you see things like the IRS reaction to flexible spending account innovations, when you see Congress cutting back on the cigarette tax that took too many years to increase to begin with, you begin to wonder about the seriousness of cost management efforts.

We are impressed with the efforts of the authors of the Kennedy-Gephardt bill and of Senator Heinz with his approach. It is too early to take a definitive view. You won't vote on it and neither will we in the immediate future. But there are many parts of it

that deserve very serious consideration and praise. Clearly, there are incentives for new medical markets and it is the first broad-brush legislation that is formally out now and recognizes the importance of achieving a balance between competition and regulation.

Equally important is the clarity of the statement that cost management does not equal poor quality. In fact, unnecessary is the worst quality care. Wasted resources are an insult to those in need and underserved.

The fact that the approach suggested in their legislation would protect access to care for the indigent would help reduce cost shifting, would support full disclosure and, therefore, for the first time perhaps true freedom of choice, are all extraordinarily positive steps in the right direction. So, too, are the increasing supports for waivers at the State level, the fact there is no automatic percentage increase for technology, and support for State health plans.

So, if you laid those out as screens for things that most major providers would like to have in a health system, H.R. 4870 gets rather good grades. Certainly, it is not something the business community can afford to reject out of hand merely because it has a Federal presence. So, too, does every piece of legislation that the business community likes to have.

There are a few issues that I think should be considered. The bill does not seem to adequately address outpatient care. It is as though all of it was going to be moving into the outpatient arena, but once there, we could ignore it because ipso facto to outpatient care was OK. I think any assessment of any other industry would suggest if you shift the focus of activity in due course, excesses will occur there as well, and we better be watching it from the beginning if that is where the economic incentives are pressing us to go.

There is an over-reliance on national norms, averages, in other words, mediocrity. Beds per thousand, admissions per thousand, length of stay—they are nothing more than perpetuation of what we want to get rid of, predicated on what has existed and what you are trying to change. We need to have policies that articulate goals we want to have, not the averages which have resulted from bad performance in the past.

The bill relies too much on measurements of a single year variety, but sweeping changes of this nature does not get measured in a single year, and it is all the more true if you allow the States up to the full 60 months to extend their period of implementation. So some larger period of performance has to be developed.

The bill is inherently too complex. There are just too many different things that have to be measured and tinkered with. In fact, that often appears to be a contradiction to the concept of a State performance based system which is exactly the concept we support. If the State has a target and can achieve that target, why does every single hospital have to have all their revenues measured at all times? It just seems, when you read through the bill, you have these conflicting forces at play between the commendable desires to set a target and let the States get to it in any way, and then at the same time we have to measure every detail along the way. Keep the Federal Government out of local project-specific decisions.

Many of the definitions in the bill are rather lacking. Reference to regional tertiary care centers, when there are no definitions of what the regions need to be—we have four regional tertiary care centers within 3 miles of this building. I don't know which one would be deemed to be the regional tertiary care center, but there would be clearly three unhappy ones as a result.

You know, what is a competitive medical plan? Can it be a single employer that goes self-funded and runs its own system highly competitively and hires its own doctors? Those definitions need to be worked on.

There is some concern that this bill does not achieve its opportunities or take advantage of them in prevention, incentives for prevention, other than just the hope that economics would prevail is a little too specious to count on.

How are these hospital revenues to be measured in increasing multihospital and multicorporate hospital systems? Will this approach merely create a shell game of shelter revenues?

The adjustment for changes in the number of discharges, while commendably sounding at first, raises the question of whether that wouldn't prop up low occupancy and low-volume institutions—exactly the opposite of the intended result.

There is also the general implication that increases in administration is automatically bad, and yet you can take another case right here in town where you have one hospital that just received a contract or is in the process of receiving a contract for all of an HMO's patient load, taking it from another hospital in town here. The result is that if you measure hospital admissions alone, the hospital getting the contract will look like it has just done something terrible. In fact, the community costs as a result of this contractual shaft are going to be significantly reduced in the Washington metropolitan area.

So all of these things, it seems to me, suggest that this legislation warrants a great deal of attention by your committee and by others and that the Heinz bill, with its commendable addition of the cigarette tax, its more indepth consideration of the market basket factor, and the catastrophic provision, also stronger support for utilization review and provider profiles could probably be married in some way with this in a further progressive sense.

Let me close by saying that the Medicare deficit ironically is proving to be a positive force for change. The worst thing in the world we could do is have Congress believe that the deficit is going away by some other method in the near future. It need to be managed, not have a patina of safety drawn across it by Federal officials who prefer to have the problem go away.

Even if there is the Social Security surplus that some have suggested, it is our very strong belief that the Congress should proceed with the basic reforms of the Medicare system without regard to whether or not there might be enough money to pay for a fraud system, as it currently exists.

Thank you very much.

[The prepared statement follows:]

STATEMENT OF WILLIS B. GOLDBECK, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH

My name is Willis Goldbeck. I am privileged to appear before you today as President of the Washington Business Group on Health. As many of you know, we are the only national organization comprised of major employers who recognized, ten long years ago, the necessity of responsible participation in health policy and cost management deliberations. Although small in number, the impact of the purchasing decisions of these companies is of undeniable magnitude: approximately 50,000,000 insured employees, retirees and dependents.

You begin today the most important health policy deliberation since the concept of National Health Insurance was rejected in the mid-1970s.

Our decisions in the next year or two will set a course of action that will last for at least a decade. In so doing, we must recognize that our society has changed at a far more rapid pace than our values or policy making process. Health policy established in the 1960s was designed to solve the problems of the 1950s. In the 1970s, we designed modifications that, at best, recognized some of the realities of the 1960s. In the past three years, we have made seven great steps forward:

1. Recognition of the changing demographics of the population with its inevitable impact on the utilization and financing of our two giant entitlement programs: Social Security and Medicare.

2. Employers replacing decades of passive payment for insurance with increasingly aggressive and sophisticated approaches to the purchasing of medical care.

3. A public movement for health promotion and disease prevention. This essential development has been delayed by continued government support for tobacco, discriminatory mental health benefits and a decade of delay in making seat belt usage both mandatory and automatic . . . delayed but not derailed as the public's interest continues to outpace the response of commitment of our institutions.

4. Restructuring the method of payment for Medicare, Medicaid capitation experiments and a significant shift by private sector employers in their own reimbursement systems.

5. Cracking the medical mystique which for so long led the public into acquiescent relationships with practitioners; confused the public about the need for more when better could actually come from less; denied the public access to the comparative quality, utilization and price measures which are essential to give meaning to our so called right of freedom of choice.

6. Technology has achieved levels of development not dreamed of ten years ago. And, the promise of ever greater life saving, life extending and quality of life enhancing technology is a lasting topic of discussion in virtually every major media outlet coast-to-coast.

7. Finally, we have a new national dialogue. Even a few years ago it was unheard of to have popular conferences on "death with dignity," bringing accountability to the medical profession, child abuse as an illness, healthy aging, self responsibility for wellness, and the ethics of resource allocation. Difficult topics, yet of vital importance to any public health policy reforms which Congress may initiate.

I mention these developments not to rehash what is known but rather to stress the point that we are already experiencing a rate of change which cannot be ignored in your current policy considerations.

A review of health in the USA in 1984 leads to several conclusions which must also shape any legislative decisions you make.

1. The progress noted above is not sufficient from either a health status or economic prospective.

2. The most progressive trends are organizationally decentralized yet scientifically and technologically centralized. To be specific, states and local purchaser groups are leading reform and provide the political, economic and human capital to make local decisions meaningful. Individuals have more alternative selections among provider organizations, payment systems and modes of treatment. Simultaneously, the ability to generate and take advantage of these opportunities is dependent upon increasing standardization of practice patterns, aggregated and centrally distributed information that gives meaning to personal choice, aggregated economic power by purchasers, and national policies that provide the incentive for a balance of market forces and regulation necessary to achieve an efficient medical care industry.

We are left with the inescapable conclusion that no totally centralized system, no matter how attractive on paper, will fit with the values and experience that are increasingly prevalent.

3. No degree of tinkering with the existing Medicare program will produce a solution to the pending deficit and close the program's coverage gaps for a population

which is actively encouraging retirement periods of 20–40 years. Neither Medicare, nor private medical insurance plans, nor Social Security were designed or financed to cover either the number of beneficiaries or the duration which tomorrow's demographics will demand.

4. Number 3, above, leads to the conclusion that Congress cannot and will not wait much longer to address at least the financial question pertaining to Medicare. Action will come no matter how loud the cries of fear from the medical industry, no matter how much the employers and unions wish to avoid cost shifting, no matter who is in the White House.

5. Prevention is just as valid and important for the elderly as it is for the young.

It is in the this context that we have reviewed the two principle bills (Gephardt-Kennedy and Heinz) before you today. We approach the task seeking to make contribution to future editions of these bills as it is our judgement that neither will be voted up or down this session. Therefore, we have consciously avoided taking a definitive position pro or con. Our comments will, hopefully, give you a better understanding of the way many leading employers view the issues raised by the bills and the solutions their authors propose.

Let me say at the start that we all owe a debt of gratitude to the Members and staffers who created those bills. They are articulate contributions to the dialogue and, as these hearings substantiate, have already reshaped future policy considerations.

Reviewing the bills' specific proposals will be easier after considering their philosophical underpinnings. Leaders in the business community who have spent considerable time on health issues have a rather clear sense of the direction the nation needs to take. Any legislative proposal will need to be measured against there principals.

1. Enhance the incentives for an economically efficient medical market.

2. Recognize that incentives for poor quality are antithetical to long term economic efficiency.

3. Minimize the federal presence in local health care decisionmaking.

4. Further balance between competition and regulation; reject the conclusion that future systems will be either one or the other.

5. Increase incentives for and direct investment in prevention.

6. Remove incentive to unilaterally shift unsubstantiated costs to private purchasers.

7. Increase the full public disclosure of provider-specific comparative quality, utilization, service and price information.

8. Give states flexibility in meeting any federal objectives.

9. Increase investment in the development and communication of outcome validated standards of medical practice.

10. Combine increased freedom of choice with incentives to select efficient providers.

11. Redress the negative economic incentives of the current medical liability system.

12. Redesign the benefits to fit the true needs of the elderly.

13. Avoid any payer escaping their fair share of responsibility for indigent care.

14. Specifically address physician's direct and indirect charges.

15. Support the further refinement of the DRG system.

16. Does not rely on traditional norms or grant a franchise to existing institutions.

17. Does nothing to negate the current employer interest or success in controlling medical expenditures.

16. Does not ignore the outpatient delivery system.

19. Will emphasize administrative simplicity.

20. Begin with an evaluation process that will foster informal congressional oversight in future years.

Measured against this list of challenging principals, the Gephardt-Kennedy and Heinz bills get very high marks. It is incumbent upon those of us in the business community to devote our energy to improving the design of those bills rather than automatically opposing them because they are federal in nature. Consistency and credibility demand that, when federal legislation meets so many of the objectives we have formerly articulated, we work with its authors rather than rejecting their efforts. It can safely be said that, without the legacy of the past years of reformed employer participation, these bills would look very different, they would be far more federal in orientation and far less open to the evolution of market forces. Our comments, which follow, are offered in this spirit.

Positive Aspects: incentives for states to control costs; protects access for the indigent; supports competitive approaches by states; recognizes that state health plans are necessary; includes a reasonable period for implementation; protects private employers from inappropriate cost shifting; recognizes that federal government should help the states be successful. In turns, this recognizes that many of the cost issues transend state borders and thus require a regional approach; supports waivers to encourage experimentation; protects against dumping of low or no-pay patients into public hospitals; specifically includes employer and unions on the state panels; allowance of discount based on volume assures that PPOs will continue to be an available option. Negotiated pricing and provider risk sharing are also supported; gives strong federal support for disclosure of competitive health plans and provider-specific comparative information; supports, intra-DRG severity measures; does not provide an automatic percentage increase for new technology; strengthens planning by basing exceptions on HSA-SHP approvals; continues incentives for HMOs and encourages public employers to use HMOs; expresses sensitivity to employer's need to avoid administrative complexities as much as possible; protects hospitals from uncontrollable costs like sudden immigration; places capital reimbursement within the DRGs; ties physician fees to DRG rate; and establishes upfront evaluations that DHHS must conduct

NOTE.—The first of these, "how the changing demographic compositions of the population of the US affect the utilization and cost of providing health care services" should receive Congressional support immediately and without regard to the rest of H.R. 4870.

ISSUES NEEDING FURTHER REFINEMENT

Is the opportunity for states to extend compliance for the full 60 months too lax? We tend to think not but it does leave the federal government with almost no negotiating position until the last minute.

The fact that the whole plan is focused on inpatient care seems to ignore the fact that all public and private sector incentive changes are designed to drive people to the outpatient setting. H.R. 4870 claims to take a "system wide" approach, which really is not the case when outpatient services are excluded.

In several instances, the bill bases action or rates upon existing national averages. We would note that, in medical care costs, utilization and capacity measures, national norms and averages are always bad. They are bad indicators because they become an homogenized fantasy not reflecting the reality anywhere. They are also bad because they are comprised of all the worst situations as well as the good ones. There is no reason for the federal government to encourage states to achieve or maintain the mediocrity that average represents. We need the federal government to look at experience across the nation and select a target range that represents excellence.

Before locking a reformed system into an age 65 base, the federal government should conduct/sponsor research to select the age that will represent real need, health status and economic conditions in the 1990s and beyond. Age 65 has no basic in medicine, science, employment, or economics. Its only basis is historical and that is a poor excuse for deciding the future.

P. 16, lines 14-20: bill sponsors should consider the use of a mutli-year performance measure since so much of the change that H.R. 4870 wants to stimulate will take more than 12 months to show measurable results of a lasting nature.

On the state panels the difference between the consumer and the independent public member is not clear.

The concept of phasing out "unfair" carrier/provider discounts is good, however, Congress must understand that some employers who benefit from current conditions will not welcome this change. This same problem is reflected in the legislative battles in such states as Pennsylvania.

The fact that a hospital is a "regional tertiary care institution" should not guarantee at higher levels of reimbursement. for example, the Washington, D.C. "region" has several such institutions, more than are needed and all are self proclaimed.

What would be the role of ProPAC during the phase-in years?

P. 27, lines 12-18: Will the "adjustment for changes in number of discharges" result in support for low occupancy, low volume facilities? If so, it is contradictory to competition and quality.

The bill is not clear to how hospital revenues will be measured for the multihospital systems which include numerous corporate entities.

The bill does not seize the opportunity to create a prevention benefit for Medicare participants. Such a program is long overdue, can be cost effective and part of the incentives not to over use the medical system.

How does Section 2125(a)(1) relate to hospitals which have completed their Hill-Burton requirements?

Due to legislation in 1984, it would appear that the Committee on Health Care Technologies will not be needed. If it remains part of the bill, then employers need to be specified as part of the membership. Also, unless you forsee an end to new technology, there is no basis to plan for the Committee's termination in 27 months.

As a matter of principle the federal government should not be involved in the decisions about local projects. WBGH has and still does support federal requirements for local planning, but the planning should be local. Also, if capital is the DRGs, there should be no reason for project specific federal review.

The bill should provide for development of new methods of paying for medical education so the costs are spread across total national medical care utilization.

Our membership is divided on the issue of mandatory physician assignment. There is a natural dislike of the federal government creating such a mandate yet there is also little sympathy for physicians. If competition works, there should be no need for mandatory assignment on outpatient services.

As an organization, WBGH holds the view that savings as a result of cost management should be shared with the employees. Each year, more companies agree with this prospective. Yet it would be misleading to suggest to Congress that the majority are at this point.

With the increase in negotiated purchase of medical care, the concept of equal premium contributions becomes a potential conflict.

Overall, there are many parts of the bill which appear to be too administratively complex and rather contradictory to the basic concept of state performance measures. If H.R. 4870 is conceptually valid, then one wonders if all the detailed hospital and physician formulas are necessary. Given the five year period at the laudable reliance on the states to use any method they wish to attain their targets, it seems success, failure, and patient access protection are really all that needs to be measured.

More clarity on what constitutes a "competitive medical plan" is needed. For example, can the employer or union declare itself a CMP?

A big increase in admissions is not necessarily bad. For example, here in Washington, a major HMO is switching its contract for some 11,000 admissions from one local hospital to another. Statistically, this increase would result in negative determinations under H.R. 4870 when factually the change represents no increase in admissions in the community, and a reduction in total community expenditures. The same problem can result for a new employer-hospital contract.

Allowing discounted rates and forbidding discrimination among payers is contradictory. Some payers will be too small, for example, to ever negotiate for a discount. Do we want uniformity or competition?

THE HEINZ BILL

Many of the items mentioned regarding H.R. 4870 apply to the bill Senator Heinz has authorized. In addition, we would note:

1. The cigarette tax is good policy . . . no matter what happens to this bill.
2. Catastrophic provision is good.
3. Impact, pro or con, of the elimination of market basket plus one percent is not clear. Anything that claims to generate $78 billion warrants full explanation.
4. Disclosure requirements about assignment are good.
5. Although the results may be economically favorable, most employers will not support a system of federally setting physician fees.
6. Increased utilization controls and provider profiles are good.
7. The regional physician contract option is very interesting. It is not clear that a requirement for majority participation is necessary or in the interests of competition.
8. Again, the need exists for a strong prevention program. We must remember that the Medicare beneficiary is going to be consuming medical care resources for periods of twenty years or more. It is not too late for the elderly to benefit from prevention.
9. PROs can establish the area admission targets, thus removing that task from the federal level. DHHS can review.

CONCLUSION

H.R. 4870 and the other bills before you advance the national dialogue. We will be available to work for the refinement of these proposals. The Medicare deficit may be the best force for change. Employers cannot afford to be left out of the decision-making process. If, as some suggest, the changes in Social Security will produce a major surplus, then Medicare, which is a Social Security program, may not be in desparate shape afterall. Nonetheless, the basic reforms in eocnomic incentives, patient education, prevention, provider accountability and benefit redesign are still needed. We appreciate being included in this critical debate.

Chairman JACOBS. Mr. Duncan.

Mr. DUNCAN. Thank you, Mr. Chairman.

I want to thank the panel. It has been a very good one. Do any of you care to comment on the dollar costs of hospital care as broken down, for example, by costs uncontrolled and not controlled by the medical profession? Mary Nell?

Ms. LEHNHARD. I would be glad to provide you some numbers, although I don't have them here with me. Some of the costs are indeed uncontrollable. One of the most difficult problems is addressing the uncontrollable costs of excess capacity. That is, you have empty beds that have to be maintained; you have to carry the overhead cost.

We believe that hospitals are now realizing they cannot carry that excess capacity and be competitive, and for the first time we see those beds closing up or being converted into nursing beds.

Mr. DUNCAN. The last time we had hearings on the hospital cost containment, 3 or 4 years ago, one of the great problems we faced was control of labor costs. No one wanted to decrease labor costs. That will be a problem again as we talk about hospital cost containment.

I understand that perhaps medical costs is only about 45 percent of the cost of the hospital, and the rest is uncontrollables—food, utilities, labor. Would you care to comment?

Mr. PETERSON. Congressman, to the best of my knowledge, that is one of our problems at this point in time. It varies from hospital to hospital, from area to area, and we don't have a handle on it, and I don't believe the hospitals have a handle on it. That is one of the reasons we feel that we have to create an incentive to examine that, an incentive for efficiency, for productivity from the businessman's viewpoint.

I think that is the ultimate solution, the solution is not to modify taxes or modify Medicare specifically, the overall problem right now is the cost of the delivery system, the inefficiencies of it, and that has to be attacked, and then I think the other things, solutions, will fall in line.

Mr. GOLDBECK. Congressman Duncan, I would like to suggest that there are probably very few things in the delivery system that are uncontrollable. The rate of increase in full-time equivalent employment went up every year for the last 5 years until the distributing system began. That was despite the fact that it could not have been clearer that that increase in employment was unnecessary by any medical measures or scientific measures or demand measures on the part of the public, and that both the Congress and the public would be putting the squeeze on to lessen the rate of ex-

penditures. The industry behaved in a way entirely contradictory to efficient management of the labor side of the equation.

We also see that there are a great many procedures now done in the hospital for a defined period of time for which there is no science based for that period of time. I would cite one example that comes to mind at this moment, normal adult hernias typically have a 4 to 6-day length of stay. Many communities don't have a single practitioner who does outpatient hernias. Yet all the major surgeons who do them on an outpatient basis find that 85 percent or more of their patients can be done outpatient and return to work in 2 days.

You have to decide whether or not that is controllable. It is controllable if the doctors change their practice patterns. They will change approximately an hour after we change the reimbursement patterns.

Mr. DUNCAN. I am aware of the fact that excess capacity is a problem. In fact, in my hometown of Knoxville, one hospital is giving a bonus to encourage people to retire, the employees, and it has affected all our hospitals there. It is a problem, as you state it.

Thank you very much.

Chairman JACOBS. Thank you, Mr. Duncan.

Mr. Goldbeck, in referring to economic incentives against overutilization, you used the word "specious". Did you mean nebulous?

Mr. GOLDBECK. Yes.

Chairman JACOBS. I thought so.

Mr. GOLDBECK. I am pleased to be corrected.

Chairman JACOBS. Would you care to comment on Congressman Bonker's proposal, Mr. Peterson, or do you want me to give your testimony for you?

Ms. WILLIAMS. We have testified before the Advisory Council that we have severe reservations about his proposal.

Chairman JACOBS. You are just not out and out against it?

Ms. WILLIAMS. I was just trying to be polite. If you would like to hear the reasons, I would be happy to enumerate them.

Chairman JACOBS. I think I know them.

Mr. DORSCH. They are contained in our written testimony.

Ms. WILLIAMS. They apply to both the Social Security Council generically, and they are equally applicable to Bonker's proposal.

Chairman JACOBS. Are there any votes for an all-payer system by which the U.S. Government would not conclude a Medicare contract with a hospital whose prices for any patient are above a certain level?

Mr. PETERSON. I think there is a vote for it, yes.

Mr. GOLDBECK. I think——

Chairman JACOBS. If we can just get you registered here in Congress.

Mr. GOLDBECK. I think a lot of employers, as they are able to find out more about charges, prices, and costs on a comparative basis, are then able to relate that more to various measures of quality and service utilization patterns and are coming to the realization that there is no great advantage in having everybody going everywhere in the system, and if it is necessary to select a number of institutions and work out financial arrangements with them, such that other institutions are not participants, that is normal practice,

and as long as your selection guarantees that your coverage receives high-quality care at a good rate, that is all right.

Chairman JACOBS. Mary Nell, isn't that pretty much how we treat nursing homes now?

Ms. LEHNHARD. You mean——

Chairman JACOBS. I mean, selectivity in concluding contracts according to level of charges.

Ms. LEHNHARD. I would like to comment on what you said, is there a vote for not being able to sign a Medicare contract if you exceed certain prices? I think clearly Medicare has done that. If you are not willing to live within the DRG rate, you can't surcharge the patient.

Chairman JACOBS. The question exceeds the Medicare patient population. I said for all payers, all of the——

Ms. LEHNHARD. My next part of the comment would be that we think other payers should do the same thing on their own. In effect, we have done that in Blue Cross. We have said to hospitals, either you negotiate and sign a contract based on a price we think is acceptable or we will do business elsewhere. Small HMO's have done it and small State employee groups have done it.

Mr. DORSCH. What you have suggested, Mr. Chairman, is really a true example of the Government using its buying power as a prudent purchaser, that is shopping among hospitals.

Chairman JACOBS. Not only what I suggested, but what I was about to say.

Mr. DORSCH. It is a description of the Government being a prudent purchaser. What we hear all the time is that Federal Government, in taking care of Medicare and limiting its payments, is a prudent purchaser. We don't agree. All they are saying is they are telling the hospitals that is what you get, period, and the hospitals have no choice and effectively simply make up the difference by charging the insurers.

We put a letter at the end of our statement graphically illustrating that in the Childrens Hospital of Philadelphia.

Chairman JACOBS. I think the essential character of the idea is, as you say, a decision by a prudent shopper, the Government, but, on the other hand, this would be conceded I think by those of us thinking in that vein, and that is that if the Federal Government could go to Lord and Taylor and still get Hecht Co. prices for the things it buys, some people would argue it is none of the Federal Government's business if the people who show up in Rolls Royces pay 10 prices for the same suit of underwear.

I recognize that as a logical argument, and I think that the answer to it is a public policy question of whether the Federal Government would use that purchasing power to exceed the immediate problem of cost to the Government, itself, for its own program. I think—I don't dismiss that as an unimportant question philosophically for the Government to answer. It is a hurdle that has to be overcome. I don't know which way the country through its Congress and its government might fall on that, but I think it is worthy of discussion.

Mr. PETERSON. One question is what is the Government paying for the services? The more significant one is, what are the services actually costing?

I would like to take the position that the problem is to cut the costs, not just cut the price that is——

Chairman JACOBS. The idea of distributing is we tell you what we will pay you, you figure out where to cut the costs, and you don't have 9 million bureaucrats looking over your shoulder and crossing T's and dotting I's. You know if you have a nephew down the street running a laundry and you are sending out towels to be laundered every week, you know where the problems are if you are the administrator or administratrix of that hospital. I think that is the general theory.

I commend the administration for its proposal in this regard. I believe they are on the, I don't say right track, I will say correct track so there will be no confusion in terms.

Further comments?

We are grateful to you for your contribution to the record.

Our final panel for the day consists of the American Academy of Actuaries, Robert Dobson, chairman; Coalition on Smoking or Health—I like that—David Neumeyer; Earline McGriff, professor, School of Education, Health, Nursing and Arts Professions, Division of Nursing, New York University; American Occupational Therapy Association represented by Susan Scott.

If the panel would proceed in the order in which they have been listed, we would be grateful.

Mr. Dobson.

STATEMENT OF ROBERT H. DOBSON, CHAIRMAN, COMMITTEE ON HEALTH, AMERICAN ACADEMY OF ACTUARIES

Mr. DOBSON. Thank you. I am Robert H. Dobson. I am a consulting actuary with Tillingast, Nelson & Warren in Jacksonville, FL. I am here in my capacity as chairman of the Committee on Health of the American Academy of Actuaries.

The American Academy of Actuaries is a professional association representing actuaries in all aspects of actuarial practice. Members of the committee on social insurance and the committee on health who jointly prepared this statement are employed in a variety of capacities. For purposes of this statement, however, we speak as professional actuaries and not on behalf of our clients or employers.

As a professional association, the academy neither supports nor opposes specific legislation to change the Medicare programs. We do, however, have a major concern that the sizable deficit projected for the Hospital Insurance Program be addressed adequately and that the way in which it is addressed be actuarially sound.

An actuarially sound, long-term solution to the deficit in financing of the Hospital Insurance Program requires a leveling of program costs relative to the taxable payroll. This can be accomplished in four ways, reduce benefits, reduce rate of increase in the cost of health care, eligibility changes, and increased revenue. A combination of actions is likely to be required.

A comparable set of considerations applies to the Supplementary Medical Insurance Program, where the financial burden is borne out of general revenue funds and beneficiary premiums.

The following comments reflect our thinking on those recommendations of the Advisory Council on Social Security—offered on December 15, 1983—which we believe have significant actuarial implications. Our comments are limited to an analysis, from an actuarial perspective, of the implications that the recommendations of the Advisory Council might have on the effective long-range operation of the Hospital Insurance [HI] and Supplementary Medical Insurance [SMI] Programs. We earnestly hope that our comments will be of assistance to Congress as it begins careful consideration of various proposals for reform of the HI and SMI Programs.

Our written statement contains additional comments on the December 15, 1983 recommendations of the Advisory Council. I would like to request that our written comments be made part of the permanent record.

We are generally supportive of the Council's recommendations. In particular with regard to recommendation 1, we believe the Advisory Council has identified the most critical problem facing Medicare. The hospital insurance trust fund faces insolvency prior to the end of the 1980's unless steps are taken to improve the financial condition of the fund. We commend the council for recognizing that a crisis exists and for urging appropriate consideration and action by Congress while time remains for corrective action.

We have limited our comments to those areas that have actuarial implications. We support, with some qualifications and cautionary comments, recommendations to fund each of the Social Security programs separately and sufficiently, to make Medicare coverage as universal as possible, and to restructure benefits and offer expanded supplementary benefits.

Other recommendations which we generally support include the proposal to index the supplementary medical insurance deductible, the proposal to limit the annual rate of growth in DRG rates used for hospital reimbursement, and the proposal to revise the current Medicare assignment system.

We raise major questions on four of the Council's recommendations. The first of these, recommendation 4, contains endorsement of the administration's proposal to tax certain portions of employer contributions to employee health care plans. The academy neither opposes nor supports this proposal. However, we have a major concern with the basis of the tax-free limits. These limits should be based on the value of the coverage provided such as is done for employer-provided life insurance. The use of a premium rate as the basis of it is inequitable. This would impose more tax on groups with higher average ages, higher female content or higher level of uncontrollable illness and injuries.

Second, recommendation 8 provides for an increase in the age of eligibility for Medicare benefits. The academy previously has testified that such proposals add more to the stability of social insurance programs than do tax increases. However, we are concerned that beneficiaries will face increasingly difficult problems in planning for retirement if the eligibility date for full Social Security retirements benefits differs from the eligibility date for Medicare benefits.

It may be difficult for retirees to obtain or afford health care coverage prior to becoming eligible for Medicare, especially if retire-

ment was for poor heath. If the timing difference is short, such as just a few months, retirees may choose to go without protection.

Our third area of concern is with recommendation 14, which proposes a voluntary voucher system. The academy does not support or oppose proposals to use vouchers in the Medicare Program. We do in fact advocate measures to introduce competition into provision of services in the Medicare Program.

There are, however, several technical problems with vouchers. The most important of these is known as skimming, the phenomenon whereby the competing corporation, be it an insurer or HMO, is able to attract healthier than average individuals. Whether or not this is done intentionally, it's clearly detrimental to the Medicare Program. Unfortunately, the current adjustment for age only partially corrects for this biased selection.

Finally, recommendation 18 advocates use of fee schedules for reimbursement of physicians. Physician reimbursement is a complex issue. While rising fees have generated significant program cost increases in the past, other factors have been equally important. These factors include use of services, mix of services, billing practices and technological advances. The academy recommends further study in this area.

On behalf of the American Academy of Actuaries, I thank the subcommittee for giving us this opportunity to testify.

Our written statement contains greater detail on the subject of Medicare. We stand ready to offer further assistance at your request. Thank you.

Chairman JACOBS. Thank you.

[The prepared statement follows:]

STATEMENT OF ROBERT H. DOBSON, CHAIRMAN, COMMITTEE ON HEALTH, AMERICAN ACADEMY OF ACTUARIES

INTRODUCTION

The American Academy of Actuaries is a professional association representing actuaries in all aspects of actuarial practice. Members of the Committee on Social Insurance and the Committee on Health who jointly prepared this statement are employed in a variety of capacities. For purposes of this statement, however, we speak as professional actuaries and not on behalf of our clients or employers.

As a professional association, the Academy neither supports nor opposes specific legislation to change the Medicare programs. We do, however, have a major concern that the sizeable deficit projected for the Hospital Insurance program be addressed adequately and that the way in which it is addressed be actuarially sound.

The rising cost of the Hospital Insurance program, expressed as a percentage of taxable payroll, can be attributed primarily to a combination of: (1) increases in the cost of health care for the Medicare population which are more rapid than increases in wages subject to taxation, and (2) demographic changes, resulting in an increase in the number of Medicare eligibles relative to the number of workers in covered employment. An actuarially sound, long-term solution to the financing of the Hospital Insurance program requires a leveling of program costs, relative to taxable payroll. With the magnitude of the projected deficit, such an accomplishment is likely to require some combination of actions: reduced benefits; reduced rate of increase in the cost of health care; eligiblity changes; increased revenue.

A comparable set of considerations applies to the Supplementary Medical Insurance program, where the financial burden is borne out of general revenue funds and beneficiary premiums.

The following comments reflect our thinking on those recommendations of the Advisory Council on Social Security (offered on December 15, 1983) which we believe have significant actuarial implications. Our comments are limited to an analysis, from an actuarial perspective, of the implications that the recommendations of the

Advisory Council might have on the effective long-range operation of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) programs. We earnestly hope that our comments will be of assistance to Congress as it begins careful consideration of various proposals for reform of the HI and SMI programs.

PROGRAM FINANCING RECOMMENDATIONS

Recommendation 1.—The Advisory Council has identified the most critical problem facing Medicare: the HI Trust Fund faces insolvency prior to the end of the 1980's unless steps are taken to improve the financial condition of the fund. We commend the council for recognizing that a crisis exists, and for urging appropriate consideration and action by Congress while time remains for corrective action.

Recommendation 3.—The Academy endorses the Advisory Council's recommendation to fund each of the Social Security programs [Old Age and Survivors Insurance (OASI), Disability Insurance (DI), and Hospital Insurance (HI)] separately and on a sufficient basis. We believe that in order to accomplish this, the Social Security Administration and the Health Care Financing Administration should continue to make short- and long-term actuarial projections using a range of assumptions in regard to future economic, demographic and other factors.

Recommendation 4.—Regarding the Advisory Council's recommendation to increase the revenues of the HI Trust Fund by earmarking funds from a new tax on employer-paid health insurance, the Academy neither supports nor opposes such a proposal. However, we do have a major concern with the technical design of the proposal being considered. That is, we believe that if there is to be a tax-free limit it should not be based on premiums, but rather on coverage provided.

Health coverage is not a commodity. It does not have a price as such. Many cases are self-insured and have no known price until months or even years after the experience period. Even in cases that are fully underwritten by an insurance company, the price charged per member of the group is often more a function of the make-up of the group than of the coverage level. We do not believe it is equitable to base the amount of tax which a person has to pay on the content of the group of which he is a member.

For example, employees who work for small employers (who cannot obtain the lower insurance premium rates available to large employers) will be taxed simply because they work for a small employer. Similarly, higher taxable premiums for the same coverage can be caused by the demographic make-up of the employee group. For example, for the same coverage, a group of employees whose average age is thirty-five may incur no tax while a group whose average age is fifty would be taxed.

A clear precedent for basing such taxes on coverage exists in the current taxation of employer-provided life insurance coverage above $50,000. In this instance the tax is based on the value of insurance coverage received, which bears no necessary relationship to the price paid for the coverage. We would be pleased to offer assistance to Congress and to the Internal Revenue Service in developing standard tables should Congress decide that taxation of employer-paid health insurance should be based on the level of coverage provided rather than on premium cost.

Recommendation 7.—With regard to the diversion of projected surplus OASDI revenues, we note that according to Social Security Administration projections, no long-term surplus will exist in the OASDI fund (despite the fact that in the short-term, due to various factors, a surplus will emerge). Therefore, we believe that any reallocation of payroll taxes from OASDI to HI will tend to place the actuarial balance of the OASDI fund in jeopardy. In order to rationally evaluate proposals to alleviate the HI deficit by diverting contributions from the OASDI fund, short- and long-range actuarial projections of cost and funding of both programs are especially important.

PROGRAM ELIGIBILITY REQUIREMENTS

Recommendation 8.—As we noted at the outset, demographic changes are one of the main reasons for the financial problems facing the Medicare system. These changes primarily affect the long-term solvency of the program. Actuarial projections indicate that while 3.2 workers now support each beneficiary, once the "baby boom" generation retires, only 2 workers are expected to support each beneficiary.

Increases in life expectancy also contribute to this problem, since benefits are paid over a longer period of time. Dramatic improvements in life expectancy have already occurred, and actuarial studies show that people who are now age 71 have the same life expectancy as those age 65 when that age was chosen in 1935 as the

age to commence retirement benefits. The projections by Social Security actuaries forecast that age 74 will be the equivalent age by the year 2000.

The Advisory Council has recommended an incremental increase in the age of eligibility for Medicare benefits from age 65 to 67 and a subsequent indexation of the age of eligibility to increases in life expectancy. As the Academy previously testified to Congress in 1983 in connection with Social Security financing, we believe that indexation of the retirement age would add more stability to the financial structure of the system.

However, it is important to note that the Advisory Council is proposing a different pattern of retirement age increases for HI than those enacted by Congress in 1983 for OASDI. Differing eligibility dates in the two systems would create significant problems for beneficiaries in setting retirement dates and obtaining health insurance coverage for themselves and their spouses between retirement and eligibility for Medicare benefits. Although these problems already exist to a limited extent (since eligibility for Social Security retirement benefits begins at age 62), they would become more pronounced if eligibility dates different from those for OASDI are enacted.

Many workers who will retire before age 67 will do so involuntarily, under the pressure of medical conditions and other factors beyond their control. It is not necessarily desirable that such persons remain in the work force. Congress should carefully evaluate the problems faced by this age group in obtaining and affording health insurance coverage, and consider a disability related entitlement for persons unable to work for health or related reasons.

Recommendation 9.—As the Advisory Council correctly points out, universal coverage would contribute to the financial stability the HI program. We support the principle that Social Security and Medicare should be universal to the extent possible. Accordingly, the Academy is supportive of efforts to achieve universal coverage, while recognizing the constitutional issues which must be resolved with respect to state and local government employees. To the extent that this approach is not feasible in the short-term, other steps might be taken to improve the cost picture by eliminating, to the extent possible, the windfalls which many persons employed in non-covered groups currently receive.

BENEFIT STRUCTURE RECOMMENDATIONS

General Commentary.—We believe that the success of the Social Security and Medicare programs represents a long-term social contract. While Congress legally has the right to change the program (and even terminate it without notice if it desires), in principle, changes should not deprive covered persons of benefits they are currently receiving or can expect to receive upon retirement. If benefit reductions are necessary, they should be made in a way which will distribute the burden of such changes as equitably as possible. Furthermore, if changes are major in nature, substantial lead time should be provided before such changes become effective, so that those affected have time to make appropriate changes in their own financial planning.

Recommendation 11.—The Advisory Council has recommended a restructuring of benefits under the Medicare programs. The changes recommended for the HI program can be expected to result in a modest net reduction (less that 1%) in program costs, with some specific changes increasing costs and some decreasing costs.

The changes recommended by the council for the SMI program involve three significant changes in the scope of Medicare. First, the enhancement of benefits under the HI program (to be made an integral part of the SMI beneficiary coverage election) serves to liberalize HI, i.e., increase benefit costs.

Second, and perhaps most important, the HI enhancement under SMI introduces premium payment into HI on a broad scale (since nearly all HI beneficiaries historically have elected SMI coverage). Part of this premium is intended to pay for the HI enhancement, and part is intended to support the program generally.

Third, the offering of enhanced SMI benefits, on an optional basis, to enrolled beneficiaries represents an extension of the scope of coverage into areas currently covered privately through Medicare-supplement policies or self-payments. Adverse selection must always be considered as a possibility in situations where individuals may elect alternative levels of benefits. However, the widespread purchase of Medicare-supplement policies by beneficiaries would suggest that a large majority would elect the proposed SMI enhancement, adding to existing coverage.

Recommendation 14.—While the Academy supports measures to introduce competition into the provision of services in the Medicare program, we must point out a

number of technical problems with proposals to use vouchers in the Medicare program.

The most important technical problem is presented by possible adverse selection (or "skimming"). Insurers may design their policies or market them in a manner that appeals more to healthier individuals. To the extent they are successful in enrolling healthier than average individuals, payment of an average amount for persons of the same age, sex, and so on—as occurs with the adjusted average per capita cost (AAPCC)—may overcompensate such insurers, and may result in higher outlays by the Medicare program. (Adjustment of the voucher for differences in the average cost of Medicare enrollees by age, as done by the AAPCC, only partially corrects for biased selection.) The present state of the art of actuarial classification is not adequate to prevent such selection from occurring.

The feasibility of a voucher program depends on the development of an index like the AAPCC which also takes into account the health of enrollees joining a particular plan. Although this is also a significant technical problem for paying HMOs based on 95% of the AAPCC, the potential for adverse selection is greatly augmented in the context of vouchers for insurance plans designed specifically to attract Medicare enrollees.

An additional problem is that Medicare enjoys a substantial cost advantage in purchasing hospital services. Unless insurers offering alternatives to Medicare paid the same hospital rates, the premiums could not be competitive.

Recommendation 15.—The Advisory Council has recommended that the MI deductible be indexed to the CPI. Under current law, the SMI annual deductible is fixed at a level of $75. Over time, inflation and utilization increases will erode the effect of the $75 deductible, resulting in an increase in SMI costs which is greater than the underlying rate of increase in the cost of covered services. With appropriate indexing, the deductible can be expected to represent a constant percentage of the total cost of covered services. We support, in principle, efforts such as this to stabilize the growth rate of the SMI program. We would note, however, that the CPI may not be the most technically appropriate index for making annual changes in the deductible, since it does not reflect cost increase patterns specific to medical services.

PROGRAM REIMBURSEMENT RECOMMENDATIONS

Recommendation 16.—The Advisory Council endorses the use of a prospective payment system for hospital services based on diagnosis related groups (DRG), and cautions that the annual rate of growth in DRG rates must be limited.

The rising cost of HI program, expressed as a percentage of taxable payroll, can be attributed primarily to a combination of: (1) increases in the cost of health care which are more rapid than increases in wages subject to taxation, and (2) demographic changes, resulting in an increase in the number of Medicare eligibles, relative to the number of workers in covered employment. The Advisory Council recommendation reflects one means of attempting to close the gap between health cost increases and average wage increases. We support, in principle, efforts to do so.

The council has recognized that the allowed rate of increase in the DRG rates will have a significant impact on the cost of the HI program. It has recommended that the Secretary of Health and Human Services (HHS) limit this increase to the rate of the change in the hospital input price index.

Future increases in the DRG rates will determine to a large extent, the stability of the cost of the HI program, expressed as a percent of taxable payroll. If such increases exceed the annual rates of increase in average wages in covered employment, HI costs can be expected to continue to grow as a percent of taxable payroll. This has been the case historically. The limitation of future DRG rate changes to those indicated by the hospital input price index will not assure level HI costs, as a percent of taxable payroll. This differential may be widened by increases in admission rates and by changes in the mix of diagnoses. However, a more severe limitation may impair the quality of and access to medical services, retard the development of continued medical technology advances, and result in substantial cost shifting to other payors.

We concur with the Advisory Council recommendation that HHS exert care to limit the rate of growth in DRG rates. We recommend, however, that an appropriate balance be maintained, and we caution against excessive reliance on this initiative as the overriding means of solving the HI financing deficiency.

Recommendation 18.—Physician reimbursement is a complex issue. The Advisory Council's recommendation of reimbursement based on fee schedules represents a significant departure from current practice and should not be adopted prior to care-

ful technical (as well as policy) analysis. Any fee schedule adopted would have to be set at fee allowances well below the current Medicare "prevailing fee" levels, in order to avoid an increase in program costs. In addition, program cost increases due to causes other than rising fees—utilization of services, mix of services, billing practices, technology—are equally important. In the past, efforts to restrict fee increases to less than industry patterns have typically been offset by increases attributable to these causes.

Recommendation 19.—Finally, the Academy supports in principle, the Advisory Council's recommendation for a statutory revision to the current Medicare assignment system, with incentives for physicians to participate, because of the recommendation's potential for cost savings.

CONCLUSION

We appreciate being given this opportunity to testify. We hope our testimony will be helpful, and we would welcome the opportunity to be of further assistance as you procede with your important deliberations.

Respectfully submitted by:

AMERICAN ACADEMY OF ACTUARIES

Committee on Social Insurance: Preston C. Bassett, Chairman; Francis M. Schauer, Jr., Vice Chairman; George E. Bell, III; Thomas P. Bleakney; Michael H. Gersie; Howard J. Levin; John B. McQuade; Cecil J. Nesbitt; Frederick Seltzer; Sammuel E. Shaw, III; James R. Swenson; James O. Webb.

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Chairman JACOBS. Mr. Neumeyer

STATEMENT OF DAVID B. NEUMEYER, ASSOCIATE DIRECTOR, COALITION ON SMOKING OR HEALTH; ALSO ON BEHALF OF AMERICAN CANCER SOCIETY, AMERICAN HEART ASSOCIATION, AND AMERICAN LUNG ASSOCIATION

Mr. NEUMEYER. Mr. Chairman, Mr. Duncan, I am David Neumeyer. I am here on behalf of the Coalition on Smoking or Health and its member organizations, the American Cancer Society, American Heart Association, and the American Lung Association. I would like to request my written comments be submitted for the record and I will summarize my statement to you.

This year Congress made a large mistake, one which will affect you, me, and our children. The nature of that mistake was in the Deficit Reduction Act of 1984. Congress chose to let the cigarette excise tax drop next year from a level of 16 cents per pack to 8 cents per pack. Cigarettes are a product which kill 340,000 Americans annually and cost the Medicare and Medicaid system more than $3.8 billion a year.

The Coalition on Smoking or Health, therefore, strongly endorses the Advisory Council on Social Security's call for an increase in the cigarette excise tax with the increase earmarked for the Hospital Insurance Trust Fund.

Excise taxes are a significant source of revenue for the Federal Treasury at this time. In 1981 when the tax level was 8 cents per pack, the Treasury received $2.5 billion. This year as a result of the increase to a level of 16 cents per pack, the Department of the Treasury has estimated that the Treasury will receive $5.1 billion in revenues from the cigarette excise tax. It is a clearly significant

sum of money for the Treasury right now, and could be for the Medicare system.

Of more concern is the effect of excise taxes on smoking behavior, particularly that of teenagers. Higher taxes mean fewer smokers. The Department of Agriculture reported that the consumption of cigarettes fell in 1983 by a total of 5 percent for the year. This was attributed largely to a reduction in the number of smokers among teenagers, 11 percent fewer smokers. This has a substantial and meaningful long-term impact on the health of these teenagers, on their health care costs, and on the Medicare system for decades to come.

Medicare and Medicaid expenditures from persons suffering from smoking-related diseases come to more than $3.8 billion annually. Smokers suffer more lost days from work, they are apt to suffer more from chronic conditions, and cause a direct drain on the Medicare system. In contrast, for 31 years the tax has remained at only 8 cents, and prior to 1982 the last increase was in 1951. During this time period the numbers of deaths and costs of cigarette smoking have continued to rise enormously.

In recognition of these factors, the Advisory Council recommended that Federal excise taxes on alcohol and tobacco be increased and the taxes earmarked for the hospital insurance fund. In its report, the Council stated that a majority of Council members recommended an increase in Federal excise tax on alcohol and tobacco products based on the demonstrated correlation between the use of these products and increased health care costs and their belief that this tax would be the most fair and equitable of the revenue enhancements considered.

In the Senate, Senator Heinz has introduced a bill entitled "The Medicare Incentives Reform Act," which calls for a doubling of the present level of the excise tax from 16 cents to 32 cents per pack. The amount of the tax would be devoted to the Medicare sytem. In his floor statement, Senator Heinz stated that the increase would require smokers to make a small but necessary contribution to offset the high cost of smoking-related illness, which is estimated to be approximately $3 per pack.

Congressman Pete Stark has a similar bill calling for an increase of 8 cents per pack, and I notice that his news release was distributed on the table this morning. His increase would be devoted to the Hospital Insurance Trust Fund.

Excise taxes are the most popular means of raising revenue in the United States. In February 1984, Time magazine reported that 77 percent of the American public supports increased excise taxes as the most popular way of raising revenue.

Put simply, Americans are dying from cigarettes. The Surgeon General has said that perhaps 10 percent of all Americans alive will die of heart disease alone if present smoking behavior continues. We suffer from lost productivity and high health care costs.

In summary, the Coalition on Smoking or Health strongly supports the Advisory Council recommendations that the excise tax on cigarettes be increased, and strongly encourages the Ways and Means Committee to adopt that recommendation. Thank you.

[The prepared statement follows:]

STATEMENT OF DAVID B. NEUMEYER, ASSOCIATE DIRECTOR, COALITION ON SMOKING OR HEALTH, ALSO ON BEHALF OF AMERICAN HEART ASSOCIATION, AMERICAN LUNG ASSOCIATION, AND AMERICAN CANCER SOCIETY

Mr. Chairman and members of the Committee, my name is David B. Neumeyer and I am submitting for the record of today's hearing the views of the Coalition on Smoking OR Health and its member organizations, the American Heart Association, the American Lung Association, and the American Cancer Society. The Coalition was founded on March 5, 1982 by the American Cancer Society, the American Heart Association and the American Lung Association to bring smoking prevention and education issues to the attention of legislators and other governmental officials. The Coalition also serves as a public policy project with the National Interagency Council on Smoking and Health, an organization backed by twenty-four private health, education and youth leadership organizations.

This year Congress has made a large mistake, one that will affect you, me, and our children for years to come. The nature of the mistake? Congress has decided to allow the excise tax on cigarettes, a product that kills over 340,000 Americans each year and adds $3.8 billion a year in costs to Medicare and Medicaid, to drop to half its current level next year. The Coalition on Smoking OR Health therefore strongly endorses the recommendation of the Advisory Committee on Social Security to increase revenues for the Medicare program through increased and earmarked excise taxes on tobacco products.

Excise taxes sound dry and uninteresting. They're not. In 1981, when the tax on cigarettes was 8 cents per pack, this single source of revenue provided $2.5 billion for the Treasury. The Tax Equity and Financial Responsibility Act of 1982 doubled the tax for a three-year period ending October 1, 1985. The Treasury Department has estimated that during fiscal year 1984, cigarette sales will provide $5.1 billion in excise revenues for the federal government. In times when the size of the budget deficit preoccupies the public and Members of Congress, and when the smallest spending cuts and tax increases provoke weeks of bitter argument and negotiation, $5 billion is a very significant sum of money. Yet the House and Senate Conferees on the Deficit Reduction Act of 1984 decided to permit the excise tax to drop next year back to 8 cents a pack, the level which was set in 1951.

Of more concern is the effect of excise taxes on smoking rates: higher taxes mean fewer smokers, particularly fewer teenager smokers. In September, 1983, the Department of Agriculture reported that domestic consumption of cigarettes fell by 4 percent in the first half of 1983. The decrease was attributed in large part to the doubling of the federal excise tax. This decrease represents a 2.3 percent reduction in the number of adult smokers, or one and a quarter million people. Even more significantly, the number of teenage smokers was reduced by 11 percent, or more than half a million. This substantial immediate impact on teenagers could translate into profound changes in the smoking behavior, the long term health, and the health costs of the next generation of Americans.

The toll from cigarette smoking is financial as well as human. Medicare and Medicaid expenditures alone from persons suffering from smoking-caused conditions are calculated to be 3.8 billion dollars annually. The value of production lost due to the fact that smokers are ill more often than non-smokers, lose more days from work than non-smokers and are apt to suffer from chronic conditions which limit their activity amounts to an additional 25.8 billion dollars annually. Thus, cigarette smoking causes a direct and substantial drain on the funds currently available to the Medicare system. In contrast, while the federal excise tax has been increased only 8 cents over the last 33 years, health care costs and lost economic productivity due to increased deaths, disability and illnesses associated with cigarette smoking have continued to rise rapidly.

In recognition of thse factors, the Advisory Council on Social Security recommended that Federal excise taxes on alcohol and tobacco be increased, with the increased revenue to be earmarked to the Hospital Insurance Trust Fund. The Council stated in its report:

"A majority of Council members recommended an increase in the Federal excise tax on alcohol and tobacco products based on the demonstrated correlation between the use of these products and increased health care costs and their belief that this tax would be most fair and equitable of the revenue enhancement measures considered."

The Medicare Incentives Reform Act, introduced by Senator John Heinz on June 13, 1984, responded to this recommendation by doubling the excise tax on cigarettes from 16 cents to 32 cents a pack. In his floor statement, Senator Heinz noted that the increase would capture an estimated $56 billion over ten years, encourage smokers to reduce or quit smoking, and require smokers to make a "small but necessary

contribution to offset the high cost of smoking-related illness, which is estimated today to be approximately $3.00 per pack."

The Coalition on Smoking OR Health strongly supports this type of assistance for the Medicare system, and so does the American public. Cigarette excise taxes are by far the most popular revenue-raising measures available to Congress according to a national poll reported in the February 20, 1984 issue of Time Magazine. The Surgeon General of the United States has declared that cigarette smoking is the single most preventable cause of death and disease in the United States and has cited evidence that unless the smoking habits of Americans change, perhaps 10 percent of all Americans now alive (24 million people) may die prematurely as the result of heart disease caused by cigarette smoking. Smoking is, by far, the leading cause of lung cancer, emphysema and chronic bronchitis. It is a major cause of heart disease. Smoking by pregnant women results in an increased risk of stillbirth, miscarriage, premature births and birth weight deficiencies. In economic terms, the yearly cost to our society of cigarette smoking in medical care, Medicare and Medicaid costs, and lost economic productivity approaches $40 billion. Congress should be doing all that it can to increase, not reduce, the cigarette excise tax because increases in the tax save lives and Medicare dollars.

In conclusion the increase in the federal cigarette excise tax proposed by the Advisory Council on Social Security will both contribute to the overall health of the American public and will generate substantial revenues of the Medicare program. Given the problems facing the Medicare system, something has to be done to provide it with adequate funding. Among the possible sources of additional funding for the Medicare program, none is more appropriate than an increase in the cigarette excise tax.

APPENDIX

Press comments on the Treatment of Cigarette Excise Taxes in the Deficit Reduction Act of 1984:

"The tobacco lobby walked off with the prize for the biggest and most undeserved tax break of the year. With cigarette smoking killing and seriously disabling hundreds of thousands of Americans every year, the conferees voted to cut the federal cigarette tax in half. Here's a decision that will cost the Treasury twice: first in the loss of billions in excise tax revenues; second in added billions in Medicare costs which—the irony is monstrous—other parts of the same bill are trying to restrain."

—Editorial, the Washington Post, June 26, 1984.

"House and Senate conferees are also working to make it easier to buy cigarettes—easier on the purse, that is. Last week's new tax package let stand a scheduled drop in the cigarette tax from 16 to 6 cents a pack, rejecting even a compromise of 12 cents. By next year, then, Government will let smokers pay appreciably less for a health risk it wants emphasized more."

—Editorial, the New York Times, June 29, 1984.

Mr. DUNCAN. I wonder if we might suspend until Mr. Jacobs gets back; we have a vote on the floor.

[Recess.]

Chairman JACOBS. Please proceed.

STATEMENT OF ERLINE P. McGRIFF, ED.D., R.N., PROFESSOR, SCHOOL OF EDUCATION, HEALTH, NURSING, AND ARTS PROFESSIONS, DIVISION OF NURSING, NEW YORK UNIVERSITY, ON BEHALF OF THE SOCIETY FOR ADVANCEMENT IN NURSING, INC.

Ms. McGRIFF. Mr. Chairman, I am Erline McGriff, here today as a private citizen but also in the roles of provider of nursing and health care services as a professor of nursing at New York University, potential consumer, and representing the Society for Advancement in Nursing, Inc.

I have submitted a written statement and request that that be part of the record.

I am very pleased to have been invited to testify and to have this opportunity to address an important issue that currently relates to Medicare expenditures. The citizens of this Nation eagerly await the results of the Medicare financing crisis, and I believe my views, which are shared by many other individuals and groups, will contribute to your deliberations and decisions.

I was privileged to testify in March 1983 before the Advisory Council on Social Security and was delighted to see that the council's recommendations encompassed the essence of my recommendation at that time, namely, that Medicare moneys be withdrawn in support of all health professions education, and that council predicted it would save about $40 billion in the next decade.

I would emphasize that I was pleased that it did not just say nursing alone but all health professions' education. My thrust today is essentially the same, to separate out costs of education from Medicare moneys allocated to care of the aged and elderly.

That hospitals may be eligible for reimbursement for nursing education costs through Medicare must be examined and questioned. Can the use of Medicare moneys for this purpose be justified? I believe that it is inappropriate for Medicare moneys to subsidize nursing education costs.

The expectation for reimbursement of clinical education costs of nursing programs seems to be a boon in moving hospitals to consider collaboration with educational institutions to offer academic degrees. To be sure, hospitals would not enter into such ventures were it not of economic benefit to them. To constitute allowable education costs under Medicare, the nursing education program must be operated by a provider, a hospital, and in conjunction with patient care activities.

In other words, Medicare will reimburse for nursing education in proportion to the percentage of Medicare patients served in that hospital. Medicare reimbursement is permitted in joint arrangements where colleges administer the nonclinical portions and a hospital administers the clinical portions. The services furnished by nursing students during this part of their education, the clinical portion, are included in the hospital's reimbursement costs. As much as 30 percent of the nursing program costs may be submitted to Medicare under this arrangement.

The national trend is to separate patient care costs from educational costs in hospitals—and this includes all educational costs such as for medicine, its subsidiaries, and nursing—because of pressures to reduce all costs and decrease Medicare funding.

How will hospitals afford such programs in the future if Medicare funds decrease? At a time when most hospitals are bailing out of administering nursing education programs because of prohibitive costs and the drain on resources from other endeavors, new and renewed efforts in this direction seem very shortsighted and perhaps even futile.

Hospitals are single-purpose agencies whose primary goal is care of patients in their institutions. Educational institutions have the responsibility for planning, implementing, and evaluating educational programs so that students will be educated to enter the service fields in meeting society's needs now and in the future. Educational institutions cannot do this in a vacuum. Rather, hospital fa-

cilities must be available, as clinical resources for learning, for students to have the opportunity to apply theory to practice and to assist them in becoming socialized into their professional roles.

Placement of nursing education in hospitals focuses nursing education squarely on the care of the sick and hospitalized person in our society at a time when nursing and health care needs are in demand in the areas of wellness, prevention of disease, and extra-institutional care—directed toward developing alternative health care delivery systems and counteracting the escalating costs of health care.

In 1965 the American Nurses' Association set forth the position that nursing education rightfully belongs in the mainstream of general education, not unlike any other profession. Nursing, as a learned profession, then belongs properly in colleges and universities.

As the Federal Government examines its entitlement programs in line with efforts to reduce the Federal deficit, it seems highly possible that most taxpayers would strongly object to subsidizing hospitals for education costs. Society has a great deal to lose if Medicare subsidies to hospitals for nursing education continue and accelerate.

I would like to just comment that in the recent issue of the "Milbank Fund Quarterly," published by MIT Press, Health and Society, and devoted entirely to Medicare that in one of the articles Professor Lave of the University of Pittsburgh raised an analogous question regarding the newly implemented DRG legislation that reimburses hospitals with interns and residents at a higher rate than hospitals without them.

And the question was raised about whether or not we really need to look at moneys for training and research in medical education being financed by moneys which is allocated from patient revenues.

I would like to emphasize before I close, one major point, that while I have spoken primarily about nursing, that if this recommendation were implemented, it would include all health professions and not single out any one of them. I thank you.

Chairman JACOBS. Thank you.

[The prepared statement follows:]

STATEMENT OF ERLINE P. MCGRIFF, ED.D., R.N., PROFESSOR, SCHOOL OF EDUCATION, HEALTH, NURSING, AND ARTS PROFESSIONS, DIVISION OF NURSING, NEW YORK UNIVERSITY, ON BEHALF OF THE SOCIETY FOR ADVANCEMENT IN NURSING, INC.

I am Erline McGriff here today, as a private citizen, but also in the roles of a provider of nursing and health care services (as a Professor of Nursing at New York University), a potential consumer and representing the Society for Advancement in Nursing, Inc. I am very pleased to have this opportunity to address an important issue that currently relates to Medicare expenditures. The citizens of this nation eagerly await the results of the ongoing analysis of the Medicare financing crisis. I believe that my views, which are shared by many other individuals and groups, will contribute to your deliberations and decisions.

That hospitals may be eligible for reimbursement for nursing education costs through Medicare must be examined and questioned. Can the use of Medicare monies for this purpose be justified? I believe that it is inappropriate for Medicare monies to subsidize nursing education costs.

The expectation for reimbursement of clinical education costs of the nursing program seems to be a boon in moving hospitals to consider collaborating with educational institutions to offer academic degrees. To be sure, hospitals would not enter

into such ventures were it not of economic benefit to them. Yet, hospitals file cost reports to their fiscal intermediaries for review and approval of such costs.

To constitute allowable education costs under Medicare, the nursing education program must be operated by a provider (hospital) in conjunction with patient care activities. In other words, Medicare will reimburse for nursing education in proportion to the percentage of Medicare patients served in that hospital. (See Provider Reimbursement Manual.)

Medicare reimbursement is permitted in joint arrangements where a college administers the non-clinical portion of the program and a hospital administers the clinical portion. The costs incurred by the hospital for patient care services furnished by the nursing students during this part of their education (the clinical portion) are included in the hospital's reimbursement costs. As much as 30 percent of the nursing program costs may be submitted to Medicare under this arrangement. A percentage equal to—if not greater than—may be charged to other third-party payers who recognize costs of hospital based educational expenses as eligible for reimbursement.

The national trend is to separate patient care costs from educational costs in hospitals (and this includes all educational costs such as for medicine, its subsidiaries, and nursing) because of pressures to reduce all costs and decrease Medicare funding. Hospitals submit that they must conduct nursing education programs to ensure an adequate source of manpower. But is this justification enough? How will hospitals afford such programs in the future if Medicare funds decrease? At a time when most hospitals are bailing out of administering nursing education programs because of prohibitive costs and the drain on resources from other endeavors, new and renewed efforts in this direction seem very short sighted and perhaps even futile.

Hospitals are single purpose agencies whose primary goal is care of the patients in their institutions. Educational institutions have the responsibility for planning, implementing, and evaluating educational programs so that students will be educated to enter the service fields in meeting society's needs now and in the future. Educational institutions cannot do this in a vacuum. Rather, hospital facilities should be available, as clinical resources for learning, for students to apply theory to practice and to assist them in becoming socialized into their professional roles.

Placement of nursing education in hospitals focuses nursing education squarely on the care of the sick and hospitalized person in our society at a time when nursing and health care needs are in demand in the areas of wellness, prevention of disease, and extra-institutional care—directed towards counteracting the ever escalating costs of health care. In 1965 the American Nurses' Association set forth a position that nursing education rightfully belongs in the mainstream of general education—not unlike any other profession. Nursing, as a learned profession, then belongs properly in colleges and universities.

As the Federal government examines its entitlement programs in line with efforts to reduce the Federal deficit, it seems highly possible that most tax payers would strongly object to subsidizing hospitals for nursing education costs. Society has a great deal to lose if Medicare subsidies to hospitals for nursing education continue and accelerate.

Chairman JACOBS. Ms. Scott.

STATEMENT OF SUSAN J. SCOTT, OTR, DIRECTOR, GOVERNMENT AND LEGAL AFFAIRS DIVISION, ON BEHALF OF AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC.

Ms. SCOTT. Thank you, Mr. Chairman. I appreciate your patience and indulgence this late on the agenda and especially thank you for the opportunity to speak with you today to offer recommendations for financial reform of the Medicare Program. I represent over 37,000 occupational therapists, occupational therapy assistants, and students of occupational therapy who serve some 5 million Medicare beneficiaries every year.

As you may know, occupational therapy is part of the multidisciplinary rehabilitation team. Our treatment of elderly and disabled people who have suffered a stroke or heart attack, have cancer, multiple sclerosis, or arthritis, directly reduces symptoms such as pain and deformity. It also greatly reduces dependence in daily life

activities, so that patients who receive occupational therapy are far more likely to remain in their homes and avoid institutionalization.

I am here today to call the subcommittee's attention to H.R. 2116, a bill introduced by Mrs. Lindy Boggs last year that would complete the Medicare coverage of occupational therapy services by extending part B reimbursement to skilled nursing facilities, rehabilitation agencies, and outpatient clinics. The bill has over 70 cosponsors in the House, and a companion Senate bill, S. 1615, introduced by Senator Matsunaga, has eight cosponsors. It does not represent a major Medicare expansion but rather a fine tuning of a system to extend coverage to less costly community outpatient settings.

Mr. Chairman, with respect to the financial crisis facing the Medicare Program, it is our contention that one of the causes is the program's emphasis on coverage, almost without limit, of costly institutional care with inadequate attention and even disincentives to the use of less costly care in community settings.

Having said that, I and my members are acutely aware of the actions that this subcommittee has taken in recent years to expand Medicare coverage of home health, comprehensive outpatient rehabilitation facilities [CORF's] and hospice care and believe these were very positive actions. However, we would urge the subcommittee to continue in the direction of expanding coverage for outpatient and ambulatory care by seriously considering proposals like H.R. 2116.

With the enactment of the Medicare prospective payment system, patients are being discharged in more acute stages of illness. Many will need to continue their rehabilitation treatment in outpatient settings. This bill would allow beneficiaries to receive occupational therapy in less costly settings. It will also make the service more accessible, by having it available in rehabilitation agencies and outpatient clinics. If patients do not receive adequate occupational therapy services to help them achieve independent living, it is quite possible that they will be rehospitalized or require greater use of costly institutional services, such as nursing homes.

The Congressional Budget Office has established a cost estimate for this legislation of $10 to $14 million. We believe this is an extremely modest expenditure of Medicare dollars compared to the benefits that would accrue to beneficiaries and the system. Moreover, the CBO estimate does not include any offsetting savings, which we contend would occur immediately if this bill is approved. Let me give you an example.

The average cost of 1 hour of occupational therapy treatment at the outpatient department of a hospital is $63, at an Easter Seal center in the community $48, and in a private outpatient clinic $36. We have estimated that if just 10 percent of Medicare beneficiaries received their occupational therapy treatment in a community setting rather than at the outpatient department of a hospital, the Medicare Program would save $2.4 million; if 20 percent did so, the savings would be $4.8 million.

Let me close with data from two studies which show the cost savings when occupational therapy is included in the rehabilitation of patients. A study of 114 stroke patients receiving 2 hours of daily

occupational therapy in a rehabilitation program found that the percentage of those able to live at home rose from 37 percent to 73 percent. The authors of the study found that 21 months after discharge, the cost of the entire program had been offset by the savings of the patients remaining at home.

Another study of 20 multiple sclerosis patients receiving therapy treatment, including occupational therapy, at a rehabilitation center found the patients improved significantly in mobility and self-care activity. As a result, the annual average cost of their care following therapy treatment dropped from $26,000 to $10,000, a savings of $16,000 per patient.

Mr. Chairman, Medicare coverage of occuaptional therapy pays off. Extending coverage to these less costly outpatient settings could pay off double or more.

[Attachments to the statement follow:]

FACTSHEET

Proposed Occupational Therapy Amendment Title XVIII (Medicare) of the Social Security Act

PROBLEM

The Medicare law is inconsistent in the provision of necessary occupational therapy services under the Supplemental Medical Insurance Program of Medicare (Part B: non-hospital medical services). At present there is no coverage of occupational therapy when the services is provided in a skilled nursing facility (under Part B) or by a clinic, a rehabilitation agency, a public health agency, or in private practice.

Occupational therapy is a fully covered service in a hospital setting under Part A and is covered under Part B in a hospital outpatient department, a comprehensive outpatient rehabilitation facility, a home health agency and when incident to physician services. It is clear that occupational therapy is a recognized medically necessary rehabilitation service, is an integral part of medical care and should be widely available in many health care settings. The lack of such coverage in a skilled nursing facility, clinic, rehabilitation agency, public health agency, or in private practice disrupts the continuum of care necessary for full recovery from illness and is an arbitrary denial of needed medical care to Medicare beneficiaries. Such inconsistency is also confusing to beneficiaries and practitioners alike and may force care to be given in a high cost setting instead of in a lower cost more appropriate setting.

WHAT THE AMENDMENT DOES

The proposed occupational therapy amendment amends Title XVIII (Medicare) of the Social Security Act by providing that occupational therapy be a covered service under Part B of Medicare when provided in a skilled nursing facility, clinic, rehabilitation agency, public health agency (as are physical therapy and speech therapy), or in private practice (as is physical therapy) when standards prescribed by the Secretary of Health and Human Services are met. The amendment also sets a limit of $500 per year per beneficiary for occupational therapy provided in a private practice setting, which is the present limit applied to physical therapy services.

The amendment would be effective, on October 1, 1983, the beginning of the 1984 fiscal year.

EXAMPLES OF OCCUPATIONAL THERAPY SERVICES

Occupational therapy is frequently required in the treatment of persons suffering from spinal cord injuries, strokes, cerebral palsy, multiple sclerosis, and severe burns. Occupational therapy covers such services as training amputees in the use of prosthetic devices, providing rheumatoid arthritics with handsplints and assistive devices, and helping the blind compensate for loss of sight.

[Attachment A]

Legislative History

Hearings, Senate Finance Committee, September 16, 1970.

Passed Senate in 1972 (Stevenson floor amendment).

Passed Senate November 30, 1973 (Bentsen Committee amendment) as part of H.R. 3153, package of Social Security amendments that were never taken up in Conference with the House.

Passed Senate, December 1975 (Nelson Committee amendment) as part of H.R. 10284 (report language attached).

94th Congress: House of Representatives—introduced as separate bills by Representatives William F. Walsh (H.R. 11621), Donald P. Clancy (H.R. 12871), J.J. Pickle (H.R. 13826), and Martha Keys (H.R. 14448).

95th Congress: House of Representatives—introduced as separate bills by Representatives William F. Walsh (H.R. 3301) and John J. Duncan (H.R. 4499 and 9294), Cosponsors: Representatives Omar Burleson, Don Fuqua, Bill Brodhead, and J.J. Pickle). Also introduced by Representative Lindy Boggs (H.R. 9826 and 9827) with 42 cosponsors. A section of H.R. 13097, Medicare Amendments of 1978, provided Medicare coverage of occupational therapy services in comprehensive outpatient rehabilitation facilities (CORF). H.R. 13097 was approved by the House 398:2 on September 18, 1978. However, no Senate action was taken.

96th Congress: House of Representatives—introduced May 14, 1979, by Representative Lindy Boggs (H.R. 4063) with 51 cosponsors. Section 933 of PL 96-499. Omnibus Reconciliation Act of 1980, defined comprehensive outpatient rehabilitation facilities as providers under Medicare, and included occupational therapy as a covered service.

97th Congress: The House and Senate reaffirmed their support of comprehensive outpatient rehabilitation facilities by rejecting the Administration's attempt to repeal the amendment.

[Attachment B]

Occupational Therapy Under Medicare

Senate Report No. 94-549 (1975) (Accompanied H.R. 10284)

Report language:[1]—"Under present law, occupational therapy services are covered under Part A when provided to medicare beneficiaries who are inpatients in medicare-approved hospitals or skilled nursing facilities. Patients receiving home health services under part A or part B are entitled to occupational therapy services only if they are receiving either intermittent skilled nursing care of physical or speech therapy. In addition to coverage as part of home health services, occupational therapy services are covered under part B only when provided to outpatients in medicare-approved hospitals. Occupational therapy services provided to outpatients in a clinic, rehabilitation agency or other organized setting are not now covered.

"The committee is concerned that present law treats occupational therapy differently from physical or speech therapy on two grounds. First, occupational therapy services are not covered when outpatient services are provided through clinics and organized health settings, although physical and speech therapy services are covered in such settings. Second, patients cannot receive occupational therapy through a home health agency unless they also require skilled nursing services, physical therapy or speech therapy.

"The committee bill, therefore, eliminates these distinctions between occupational therapy and the other therapy groups. It expands the outpatient physical therapy and speech pathology benefits as provided through clinics, rehabilitation agencies, and other organized settings to include occupational therapy. Additionally, it amends the requirements for patients to qualify for home health services to provide that a need for occupational therapy alone can qualify the homebound patient for this benefit. However, the need for occupational therapy alone would not qualify a person for the service of a home health aide.

"In administering the occupational therapy benefit, the committee intent is to have the Department of HEW apply the definition, guidelines, and criteria as to

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[1] The 1975 report language includes a discussion of amending the Medicare home health benefit providing for occupational therapy as a qualifying service; such a provision is not included in the proposed amendment.

covered and noncovered occupational therapy services included in the "Skilled Nursing Facility Manual" Revision No. 109, issued by the Social Security Administration in November, 1975."

SAVING MEDICARE DOLLARS

(By Hon. Ron Wyden of Oregon, in the House of Representatives)

Mr. WYDEN. Mr. Speaker, medicare is facing bankruptcy and we are facing some tough choices in finding solutions to this enormous problem. I believe that we need to examine all less-costly means of providing high-quality health care in looking for ways to bring medicare back to solvency and curtail the high cost of health care.

One of the alternatives we should examine is medicare reimbursement of occupational therapy services on an outpatient basis.

Occupational therapy (OT) services are a vital means toward rehabilitation and independence for stroke, heart attack, and arthritic patients. Currently, these important services are reimbursed under medicare only when performed through the outpatient department of a medicare certified hospital. Occupational therapy services provided in this setting are far more costly, generally, than in community settings, such as rehabilitation agencies or outpatient clinics.

In fact, the average cost of 1 hour of occupational therapy treatment in the outpatient department of a hospital is $63. But the same hour of treatment provided by a rehabilitation agency, such as an Easter Seals Center, is $48 and in a private outpatient clinic is only $36.

Mr. Speaker, I think it is ludicrous under any circumstances for medicare to be paying almost twice as much for OT services than it has to, and under today's financial circumstances, it makes no sense at all.

I firmly believe we should take a close look at the cost-saving possibilities in providing occupational therapy services in community settings and that we should move toward such reimbursement practices if savings would occur. Even beyond the fact that patients would benefit by OT services in community locations, the possible cost savings are just too good to overlook.

Chairman JACOBS. Thank you very much.

Ms. Scott, are you conversant with the Congressional Budget Office estimate of this bill?

Ms. SCOTT. Yes, Mr. Chairman.

Chairman JACOBS. What are those numbers?

Ms. SCOTT. The CBO estimate is $10 to $14 million in additional costs to the program.

Chairman JACOBS. How does that go up with any savings?

Ms. SCOTT. The CBO estimate did not include any offsetting savings. They did not look at offsetting savings.

Chairman JACOBS. We better ask them to do that, hadn't we?

Ms. SCOTT. We have asked them to do that, Mr. Chairman.

Chairman JACOBS. OK; the committee is grateful for the testimony of the panel. Are there additional comments?

If not, thank you very much. We appreciate your attendance.

Our final witness for the day is Samuel Wallace of Washington, DC.

STATEMENT OF SAMUEL B. WALLACE, WASHINGTON, DC

Mr. WALLACE. Thank you, Mr. Chairman.

Chairman JACOBS. If you have a statement, you can hand it in or whatever, but proceed in your own manner.

Mr. WALLACE. I handed the statement in, yes.

Chairman JACOBS. I'll tell you, we normally go 5 minutes per witness. The bells just rang, which means 15 minutes before the vote and somewhere around 5 minutes from now we will have to close down. OK?

Mr. WALLACE. Thank you very much, Mr. Chairman.

Mr. Chairman, Chairman Jacobs and members of this committee, it is a honor and privilege to appear before your committee and to give testimony on H.R. 3884, the Health Service Act. My name is Samuel B. Wallace, and I have done medical research as a practitioner in Brazil and I have done independent medical research for the last 10 years at the National Medical Library in Bethesda, MD.

As Senators Kennedy, Gephardt, and Congressman Dellums, sponsors and cosponsors of H.R. 3884 have noted, the Health Service Act is intended to provide comprehensive health care services to all residents of this country. The current private sector approach to health care aided by Medicare and Medicaid health insurance has made the United States about sixth in the world in terms of the level of our health care and the rate of cure for various illnesses. The United States, despite such a poor result, spends more for health care than any other nation on Earth, which is about $30 billion per year, or approximately 30 percent of our annual GNP.

The sponsors and cosponsors of this bill have proposed a comprehensive national health service which would be available to all. My approach is more modest. I think that this bill should be directed toward extending health care to those areas of greatest need which is the poor, elderly, and middle class living in urban and rural areas. I also suggest that traditional health care can be strengthened in all areas by extending the scope of the duties and service of limited medical practitioners such as registered nurses, physician assistants, respiratory therapists, and licensed pharmacists.

I have made this suggestion under the general assumption that health care in the affluent suburban areas of our country is adequate and sufficient. I also think that my position is sound because it should not be necessary to construct an entirely new system when we have an existing functioning health care system already in place. Replacing the current system with an entirely new system would in my opinion be prohibitively expensive and conceivably might not yield any better results in improving health care. To take such an approach would also be wasteful in terms of utilization of existing hospital plant and clinic facilities, not to mention the problems likely to be encountered with respect to anticipated changes for highly educated and trained medical personnel who might prove unwilling and unable to adapt to such a completely new system.

There is also the fact that many, many hospital beds are not being utilized and in many communities there is a necessity of reorganization of existing facilities in order to achieve maximum use and service for the community.

I do share with the sponsors of this bill their concerns about both the quality and availability of adequate health service as it exists today for both the poor and the rich. I honestly believe that when we consider the vast amounts of money that we as Americans have spent for the present health care system, we have not as a nation received adequate services commensurate with the value of our massive investment.

However, boldly substituting a public system for the currently highly subsidized private system could be rather disruptive and

might not utilize the full capacities of our health resources as they exist today.

And while I feel that a more modest approach to adequate health care would provide good results particularly if such a system were made highly competitive, given present circumstances, I do feel that the general thrust of proposals in the bill for national health service to fulfill the health needs of the poor in urban areas and the poor in rural areas is a sound one. I feel that those proposals for providing new clinics and, where needed, new hospitals are excellent, though, studies should be made to determine where underutilized or abandoned existing facilities are available. Those should obviously be used. It is also obvious that the Government could very readily step into the process of training doctors, nurses, and pharmacists to serve in those areas of greatest need because under the present circumstance the universities and medical schools are largely training medical personnel to work in our more affluent areas even though such institutions are heavily subsidized by the Federal Government.

There is also some concern about the standard of medical education and whether those medical people are being properly trained in the science of medicine. Therefore, when this bill becomes law in its final form, it would provide the basis for establishing new medical facilities, such as hospitals and clinics in some instances as well as new medical training facilities, while at other times it would provide the basis for supplementing or improving existing facilities. And of course ideally all of this would be accomplished with a minimum of bureaucratic activity.

The second part concerns expanding the scope of duties and services for limited health care practitioners—pharmacists, nurses, and respiratory therapists.

I am sure that some members of the committee are asking themselves how this topic is related to the national service bill. It is. Because the more narrowly the professional standards for nondoctor medical professionals are interpreted, the higher are the costs for medical care and the less likely is the possibility that the poor, elderly, and middle class will obtain proper medical care.

This is a very complex problem. But it is a fact that the more tightly the physician has a monopoly control over the prescribing and the dispensing of curative medicines such as antibiotics, the more costly the care and the greater possibility of unnecessary surgery.

The real question is whether professional standards determining the scope and extent of duties for health practitioners who are not doctors are geared to protect the general public against incompetent medical practitioners or whether they are designed primarily to protect insiders against competition. This is a vital question indeed. It is important because uncompetitiveness for health care practitioners in the current system or a new one is one of the principal reasons for inefficiency, poor treatment, excessive surgery and high medical costs. Let me illustrate.

Let us suppose for the sake of argument that doctors or scientists closely allied to the medical profession had discovered new curative medicines which were very safe and produced cures in relatively short periods of time. Then it was determined that only doctors

could prescribe these new medicines, and finally a group of doctors got together and determined without sound scientific basis that these medicines had suddenly become totally ineffective in treating disease. Then the same doctors with the monopoly over prescription drugs decided that instead of administering these curative-type drugs that pain killers would be given for many of the illnesses that those drugs were capable of curing.

The result would be that medical costs would burgeon, that many illnesses would be prolonged and the need for treatment would be greatly extended and many types of curable diseases would now be classified as incurable. Naturally, the number of surgical procedures would increase.

What I have described is not a hypothetical case. It is in fact a brief history of antibiotic medicines. Medicines that the FDA's Physician's Desk Reference certified were safe and effective in curing a wide range of illnesses, were falsely downgraded by doctors. This led to a great expansion of "painkiller," nonprescription drug industry dedicated not to the cure of illness, but to temporary relief from pain.

Several courts have recently ruled on these and similar issues pertaining to the duties and responsibilities of health care practitioners other than physicians. The tendency of these decisions has been to allow the limited health practitioner sufficient authority to allow him or her to prescribe and dispense curative medicines without the supervision of the physician in certain instances.

And in one decision a patient himself was permitted to prescribe his own medication "for reasons of medical necessity."

In one case a national health corpsman, licensed in New York as a physican's assistant in another State wrote a prescription without the physician's signature. The U.S. Court of Appeals, Fifth Circuit, established jurisdiction and ruled that the charges be dismissed because if they were not, the result would be a decrease in the quality of available health services the region served.

In another case, a Missouri State court went further in ruling "a nurse may assume responsibilities not previously considered to fall within the nurse's profession, if those responsibilities were in line with the nurse's specialized education, judgment, and skill based upon a knowledge and application of principles derived from the biological, physical, and nursing sciences * * * "

And in the District of Columbia, laws have been passed granting the nurse practitioner, who is one step above the R.N., clinical privileges and staff membership at various D.C. hospitals. Of course, such clinical privileges are contingent upon the proper professional qualifications in terms of education and experience. The hospital's governing board was also charged with the responsibility to see that the denial of such clinical privileges to nurse practitioners when they do occur was a legitimate one and not one based upon anticompetitive intent.

Those mentioned laws and cases indicate that there is a growing awareness of the necessity to expand the nonsupervised duties and responsibilities of the limited health care practitioner to include the prescription of curative medicines and the diagnosis of simple illnesses.

Chairman JACOBS. If you could wind it up, Mr. Wallace.

Mr. WALLACE. Yes, sir.

The pharmacist must major in organic and inorganic chemistry before entry into pharmacy school. He studies chemistry and medicine for 4 years, including 1 year biochemistry, biomedication, and pharmacology. The medical student studies general chemistry and parmacology for 1 year. Yet, it is the doctor who enjoys a monopoly over the prescription of curative medicines. While the pharmacist, who is better trained and educated for a longer period of time in the science of medicine is prohibited from prescribing curative medicines, such as antibiotics. Until the point is arrived at where patients can receive curative medicine for their illnesses, we will have great difficulties with the cost of medical care in this country.

Thank you.

[Portions of the statement not read follow:]

Probably, the most glaring example of the inadequacies of existing professional standards laws and rules is that of the pharmacist who is denied the prescription authority of the physician.

This fact is interesting because Pharmacists generally are required to study more about the subject matter of medicine and the related subjects of chemistry, biochemistry and pharmacology than are M.D.'s!

Thus while the doctor is required to study chemistry for one year as a medical student with a few other interspersed courses in Biochemistry and a six months course in Pharmacology, the pharmacists spend four years studing chemistry and two years studying pharmacology. The question then arises who is better equipped to know and prescribe medicines in terms of both their curative and adverse effect. The Doctor or the pharmacists?

It would seem better from both the standpoint of those who are ill and who know the nature of their illness and from the standpoint of the pharmacists who generally has by his education, training and experience a greater knowledge of medicines and their effects to be permitted to prescribe curative "noncontrolled medicines" such as the common Antibiotics and be permitted to dispense those curative medications where the need arises. And the fact that the pharmacists today are not permitted to prescribe such curative medicines as the common antibiotics may be a flagrant violation of the Antitrust Laws with respect to his legal and professional right of competition due to his superior education and training and experience in the field of medicines. And under the reasoning of the D.C. Law and that of various court decisions just mentioned, qualified, registered nurses, respiratory therapists and physician assistants as well as pharmacists and pharmacologists should have the authority to write prescriptions for curative medicines whether in a National Health Service Program or in ordinary field of Health Care.

I would suggest that any form of incorporation of such procedures into Health Care Services improve Health Care Quality and lower Health Care Costs. And by making the public and private Health Care Systems truly competitive cure rates would be raised and many lives saved. Consequently the entire medical health care system would be substantially upgraded by new laws incorporating new Health Care Practicioner's Professional Standards so modified that the patient can receive the maximum benefit from those Professional's education, training and experience who come in closest contact with the patient on a day to day basis.

Probably, the most glaring example of inadequacies of professional standards laws and rule is that of the pharmacist versus the doctor. Because the M.D. may study chemistry for more than two years including a six months course in pharmacology. While the pharmacists ususally studies chemistry for a full four years and may study pharmacology for two years. The question then arises who is better equipped to prescribe medicines for those whose sickness is known. The physician or the pharmacists who has studied more about the chemical composition of the drugs that he mixes to form a medical prescription, who knows the curative as well as the possible adverse effects of the prescription medication. The fact that the pharmacist is not allowed to prescribe simple curative medicines such as the Antibiotics may be an indication of a flagrant violation of the Antitrust laws with respect to his legal rights of competition, since the education, training and experience of the pharmacist with respect to medicines is generally superior to that of the physician. It would therefore seem just that the Pharmacist who is licensed should be given the authority to prescribe curative medicines for simple diseases. And under the reasoning of

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the D.C. Law and that of the variouss court decisions just mentioned in this paper, qualified nurse, practicioners, registered nurses, respiratory therapists and pharmacists should have the authority to write prescriptions for curative medicines such as the Antibiotics when the nature of the illness is generally known to the patient and the pharmacist.

It therefore seems very probable that extending the scope of authority for prescribing simple curative Antibiotic medicines by nondoctor medical practicioners would introduce true competitiveness in the Medical Health Care Marketplace and would ensure that those who were ill would generally be able to obtain the proper curative medicines when they were sick.

It might well be that such a competitive system might lower medical health care costs substantially while simultaneously raising the cure rate and saving lives. And consequently the entire medical health care system would be substantially upgraded by these simple new laws regulating Health Care Practicioners' Professional Standards so that the patient can receive the maximum benefit from that Professional's education, training and experience.

Chairman JACOBS. Thank you very much.

Mr. WALLACE. Do you have questions about the standards or anything?

Chairman JACOBS. I don't think so. We have your statement and we are grateful for it.

Mr. WALLACE. I want to thank the committee for this opportunity to speak. Thank you.

Chairman JACOBS. We thank you.

The committee has concluded its hearing.

[Whereupon, at 1:40 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF THE AMERICAN LUNG ASSOCIATION

The American Lung Association welcomes this opportunity to present comments to the House Committee on Ways and Means, Subcommittee on Health regarding recommendations for Medicare Financial Reforms. Established in 1904, the ALA is the nation's oldest voluntary health association. While we began working to control and prevent tuberculosis, our current mission now encompasses the broad spectrum of all lung diseases.

The ALA believes that new sources of revenue for Medicare must be found. Failure to do so may limit access to care for many Medicare beneficiaries, especially those with chronic conditions such as lung disease. The ALA supports the use of the federal excise tax on cigarettes as an additional financing mechanism for the Medicare program.

SCOPE OF THE PROBLEM

Respiratory diseases consitute a devastating public health problem in the United States, in the aggregate ranking third among the leading causes of death and sixth among conditions responsible for premature retirement for disability. Respiratory diseases constitute an array of conditions of the lungs and the upper respiratory system. Between 1968 and 1979, Chronic Obstructive Pulmonary Diseases (COPD) showed the most rapid increase among the 10 leading causes of death with a 60% increase in that time period.

COPD comprises six unique diagnostic categories with various causes, some unknown. Current medical therapies do not alter the course of the disease when initiated after significant impairment has developed. Treatment requirements for the patient with COPD are unavoidably complex and long term, and involve many providers and levels of services. There are many impediments to the health care needs of the COPD patient including availability of resources and financial restrictions.

Lung disease is a common affliction of persons over age 65. Moreover, as the average life span continues to increase there is greater likelihood of significant lung problems developing in this population. As the elderly segment of the population has increased, gerontologists has examined the influence of aging on normal lung function and found that aging is associated with a gradual decline in the performance of the lungs such as maximal flow rates, vital capacity, and arterial oxygenation. In general elderly persons have three related reasons for multiple acute care

hospitalizations related to pulmonary problems associated with aging: biventricular failure, exacerbations of COPD with infections, and arrythmias.

The most recent data provided by the Health Care Financing Administration indicates that in the population over 65 years or disabled there were approximately 308,085 hospital discharges recorded for patients with COPD in FY 1980. Reimbursement to medical providers for services provided to Medicare beneficiaries with COPD totaled $605 million for FY 1980. Of the 308,085 discharges for COPD, an estimated 80 percent can be considered to have a tobacco smoking related etiology, that is they are large airway obstructive diseases. The remaining 20 percent are related to repeated respiratory infections or unqualified bronchitis.

The total financial burden of cigarette smoking, when other major diseases are also considered such as heart disease and cancer, is staggering. The yearly cost to our society from cigarette smoking in Medicare and Medicaid costs, general medical care covered by third party payers, and lost economic productivity approaches $40 billion.

MEDICARE FINANCIAL REFORMS

The Medicare program is projected to have a significant deficit by 1995. Steps must be taken to improve and stabilize the financial outlook for this program. Failure to do so will jeoporadize the health care of all Medicare beneficiaries and ultimately, as is the case with the COPD patient, their health status.

Proposals being considered to address the funding problems which include revisions to eligibility requirements, increases in premiums, or benefit changes are only partial solutions and are questionable when the negative impacts to the beneficiary are examined. Of primary concern are the additional expenditures for health care that will be borne by the beneficiary and the resulting limitations on their access to adequate health care.

The ALA believes that new sources of revenue must be explored. As such, the ALA endorses the recommendation of the Advisory Council on Social Security that the federal excise tax on tobacco be increased, with the increased revenue to be earmarked for the Hospital Insurance Trust Fund. In its report the Council stated, "A majority of Council members recommended an increase in the federal excise tax on alcohol and tobacco products based on the demonstrated correlation between the use of these products and increased health care costs and their belief that this tax would be the most fair and equitable of the revenue enhancement measures considered."

The ALA supports the use of the excise tax on cigarettes as an alternative financing mechanism for the Medicare Hospital Insurance Trust Fund on the concept of a user tax. An excise tax on a specific product such as cigarettes, since this is not broadly based, will tend to be less regressive and less inflationary than other types of taxes which might be considered. Cigarette excise taxes are also by far the most popular revenue-raising measure available to Congress according to a national poll reported in the February 20, 1984 issue of Time magazine.

The ALA was extremely disappointed in the action of Congress in early summer which reduced the cigarette excise tax to its previous level of 8 cents. This windfall to the cigarette industry is at the expense of the American people. Cigarettes represent a significant factor in our health care costs including those of the Medicare program. An increase in the cigarette excise tax is an appropriate source of additional revenue for the Medicare program. We urge you to accept the recommendation of the Advisory Council on Social Security to raise the federal cigarette excise tax. The ALA believes this will generate substantial revenues for the Medicare program while addressing a major health problem for this country.

JOINT STATEMENT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION AND ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY

Mr. Chairman, Members of the Committee; this testimony is being submitted on behalf of the Association for the Advancement of Psychology and the American Psychological Association, organizations representaing 72,000 psychologists nationwide.

We are pleased to respond to the subcommittee's request to comment on the Medicare financing crisis, the recommendations of the Advisory Council on Social Security, and H.R. 4870 (the Medicare Solvency and Health Care Reform Financing Act of 1984).

THE HITF PROBLEM

We understand that the Hospital Insurance Trust Fund (HITF) faces two distinct financial pressures. First, hospital insurance expenditures represent a rising proportion of total federal expenditures and will continue to accelerate over the next five years. Second, present projections indicate that the HITF itself faces potential insolvency in the coming decade.

The Hospital Insurance (HI) portion of Medicare covers hospital and home health and skilled nursing care for 30 million aged and disabled persons. Outlays for HI are projected by the Congresssional Budget Office (CBO) to grow substantially faster than revenues and the balance is predicted to fall to zero in the mid 1990s. In 1985, total outlays are estimated at $48 billion. Income is estimated at $52 billion, leaving an accumulated balance of $20 billion. By 1995, total outlays are estimated at $146 billion, with an accumulated balance deficit of $56 billion.

The average total outlay growth of HI, even with the reductions of the diagnostic related grouping (DRG) controls imposed recently, is estimated at 11.8 percent per year.

Revenues come to the trust fund through payroll taxes, interest earned on balances and from general revenue transfers. Income growth is expected to keep pace with outlays only through 1989. After that, the trust fund balance is expected to decline rapidly.

It is our contention that there are substantial opportunities for the reduction of outlays that are ignored by the current structure of Medicare.

In the next four decades the American population is projected to grow by nearly 30 percent with the elderly population doubling to an estimated 58 million or nearly 20 percent of the population by the year 2025. Forty percent of the elderly are presently over the age of 75 and this percentage is constantly growing.

Although comprising eleven percent of the total population today, persons over 65 make thirty percent of all visits to office based physicians and account for 43 percent of all hospital expenditures. Older patients have an average length of stay 76 percent greater than younger patients. The percentage of the population suffering from chronic conditions increases from 8.9 percent of those age 17–44 to 24.1 percent of the 25–64 age group, to a staggering 46.4 percent of those over the age of 65.

Persons over age 65 account for 20 percent of all reported suicides and occupy thirty percent of all public mental hospital beds. As high as 30 percent of the elderly experience depression and 18 percent have problems with alcohol. Of the five percent of the elderly who are nursing home residents, 50 to 75 percent experience some form of emotional or behavioral disorder.

Current research asserts that up to 20 percent of persons currently institutionalized as senile have been falsely diagnosed by their physicians. The Conference on Treatable Diseases in the Elderly reported that one of the largest single causes of these false diagnosis is drug poisoning from overmedication. Robert Butler, former Director of the National Institute on Aging, has stated that more than 100 reversible syndromes, including depression, may also mimic senile dementia.

All of these problems contribute to the increased cost of Medicare, especially to some of the most expensive costs of Medicare such as nursing home beds, acute care hospital beds, and state mental facilities.

Yet, only four percent of those patients seen in outpatient public and private mental health facilities and two percent seen in inpatient settings are over age 65. Medicare payments for inpatient mental health treatment represents only 2 percent of the total Part A expenditure, and less than one percent of the total Supplemental Medical Insurance (SMI) reimbursement under Part B outpatient treatment. These percentages are substantially below the proportion of the mentally ill elderly in the population.

Medicare covers on the average only 44 percent of the elderly's health care cost, and nearly 66 percent of the elderly supplement Medicare with private insurance to guard against large uncovered charges. Most of these supplemental policies are designed to cover the copayment and deductibles required by Medicare. Furthermore, additional benefits are shaped by Medicare which ignore the mental health needs of the elderly.

The Medicare program, enacted nearly 20 years ago, continues to place its emphasis on short-term, acute care hospitalization in lieu of low cost outpatient alternatives to that care. To the extent that the Prospective Payment System encourages some hospital-based activities to be shifted to the outpatient sector, then Medicare Part B should be examined carefully for opportunities to provide less costly outpatient care.

A SHORTAGE OF MENTAL HEALTH SERVICES

One notable gap in Medicare is the continued capping of benefits for the outpatient treatment of mental health to a $250 Federal share, matched by a similar patient copayment. We know that the cost of elderly Medicare beneficiary outpatient charges (reasonable cost per enrollee) has increased more than fourfold since 1967 (up from an average of $103.44 in 1967 to $416.92 in 1981). Yet, there has been no recognition of the impact of such increased cost upon the treatment of mental health. If we were to assume the same increase for the treatment of mental health needs, the $250 limit is now worth ¼ of what it was in 1967, or $62.50. The outpatient Medicare mental health benefit is worth just over one eighth of the cost of the Part A and B deductibles and Part B premiums paid by today's Medicare beneficiaries. That is hardly adequate treatment. Effective outpatient intervention for depression, psychosis or other treatable, reversible disorders of the elderly is, in effect, denied at such a reimbursement level. The physician's alternative for his or her patient, to date, has been more expensive, not always necessary, hospitalization. This alternative may or not be medically or psychologically essential. It is a necessity due to Medicare law, but it is not necessarily cost-efficient.

Mr. Chairman, we have testified before this Committee many times in the past and documented the positive cost benefit associated with provision of outpatient mental health services and the efficacy and cost effectiveness of reimbursing psychologists for providing these benefits. Studies published since our last testimony before this committee on those subjects in December 1982 have only reinforced what we said then. For certain chronic conditions, mental health interventions in conjunction with hospital care have been shown to hasten recovery, reduce lengths of stay by as much as two days and promote patient adherence to treatment regimens.

THE NEED FOR PREVENTIVE SERVICES

One of the recommendations of the Advisory Council on Social Security, with which we strongly concur, is that the elderly can benefit from prevention oriented programs and screening procedures.

As the Medicare eligible become more numerous and contributions to the fund decrease and cost continues to escalate, steps must be taken to reduce the need for utilization of Medicare services.

Research by psychologists and physicians has demonstrated that psychological treatments can help people stop or reduce habits that increase their risk of heart disease and cancer, as well as reduce stress, thus reducing the risk of high blood pressure and other physical disorders. These are all areas at which the elderly are particularly at risk.

Large scale intervention programs for communities and businesses have been successfully tested and several leading universities have established programs to improve the health of persons in cities or counties. In one case, a team of psychologists, physicians and communication specialists at Stanford University developed a two year program that trained persons in two cities with populations above 12,000 to self manage health risk behavior. In the experiment, risk of heart of disease decreased substantially. Blood serum cholesterol, blood pressure and saturated fat consumption all were decreased.

Satisfactory reductions of health care cost can only be achieved by making major changes in the present Medicare law which stifles innovation, economically discourages outpatient treatment, prevents the majority of non-physician health care practitioners from rendering services, suffocates competition, and encourages the use of the most expensive treatment settings. Medicare offers those at risk no support for engaging in early screening and diagnostic strategies and preventive health care.

TAXING HEALTH BENEFITS

An example of bad public policy posing as fiscal restraint is the Advisory Council proposal to place annual limits per family and per individual on the amount of tax-free contribution employers could make to worker health insurance plans. Any amounts over these limits would be taxable as income to employees.

Placing a limit on tax-free employer contributions to health insurance and making any amount over that taxable as income to employees, would provide a strong incentive to shift employer contributions which exceed the federal cap to other tax-free or tax-deferred benefits. This would lead to no increased revenue for Medicare and less available health care services.

Eliminated altogether, the tax-free status of employer health care contributions would force millions of low and middle income workers and families to give up protection against the high cost of illness.

Employers contribute about the same amount for health care coverage per employee regardless of income. As a result, health benefits as a percent of income are more valuable to families at lower wage levels. Limiting tax-free contributions would, therefore, place a disproportionate burden on middle and lower income workers who would find it more difficult to maintain their coverage. Individuals with higher income could purchase supplemental health insurance policies to assure their present coverage is not interrupted.

If tax preferences for health care contributions are scaled back, the benefits which are traditionally eliminated are mental health, alcohol and drug abuse, preventive care, outpatient diagnostic services, and similar services. This subcommittee heard substantial testimony on the cost effectiveness of such benefits during your December 1982 Medicare hearings. What would be left intact is coverage for hospital and surgical benefits which have been the major source of our health inflation problems and over which patients have little control.

H.R. 4870

H.R. 4870, the bill introduced earlier this year by Representative Gephardt, the Gephardt-Kennedy bill, relies on a new coating of regulations at the state level, which not only duplicates for the Medicare program the mechanisms in place for the various state Medicaid programs, but imposes on the states federal criteria which would infringe on the right of states to license providers, determine benefits and administer their own programs.

It is difficult to believe that this proposal which would mandate an elaborate federal and state administrative mechanism to set expenditure levels for each state, to evaluate the performance of state rate-setting programs and to regulate utilization and prices could reduce costs.

While the bill encourages states to develop their own rate-setting methods, the states would have no discretion as to the level of expenditure that would be permitted and would have no practical alternative to administering a state operated version of the failing federal program. What is worse is that the Gephardt bill would infect the states with the inappropriate limitations on programs and providers that has been so debilitating to Medicare. The bill H.R. 4870 would bring to a halt current positive changes that are taking place in the health care marketplace.

Psychologists in outpatient settings have been providing services through HMOs, PPOs and other structures. The Federal government acts to restrict reimbursement to non-physician practitioners so that, at this time, Medicare is the only nationwide health care financing program that does not yet recognize psychologists as fully qualified practitioners.

The advantage for overall cost and patient care where nonmedical expertise is effective when used is well supported by research. The findings of a small group of researchers who have examined the effects of mental health treatment reducing the overall cost of medical care submit this statement, and we quote: "An enormous body of literature suggests emotional factors may play a role in the disease process and treatment. Disease may be caused by or aggravated by emotional distress, all with consequences for the course of disease recovery, maintenance of health and use of medical services."

State laws which allow access to a variety of health care professionals require that health insurance plans that include benefits for services that psychologists by State law may provide, must allow patients to have "freedom of choice" of practitioners. These statutes representing more than 88 percent of the U.S. population, and affecting 89 percent of all licensed psychologists, have been uniformly supported by both State and Federal courts.

Recognition of psychologists and other credentialed nonmedical health professionals would clearly benefit efforts to decrease health care cost. We do not think there is any question about the fact that psychologists charge less per patient visit than psychiatrists. In a study by Richard Frank, assistant professor of economics and psychiatry at the University of Pittsburgh School of Medicine, it is concluded that in states with "freedom of choice" laws, fees for psychiatrists are lower than in states without these laws—between 8.3 and 9.5 percent lower.

In its present form, H.R. 4870 would emasculate existing state freedom of choice laws by imposing the Medicaid definition of "physicians' services" upon all state health care plans. Licensure has traditionally been within the province of state government, and the states' authority to legislate in this area should not be usurped for

the sake of achieving uniformity. Granted, the Federal government has a legitimate purpose in setting a minimum standard for the level of care that each state must provide. But under the proposed legislation, that "minimum standard" would act as a ceiling for any state that has enacted freedom of choice laws. The consequences of having the federal definition supersede state law would be paradoxical to the intent of this legislation: health care cost would rise as a result of less competition and patient care would decline with a reduction in the choice of providers. In short, the well-intended drafters of this legislation may be precluding the very reform that they had hoped to attain. And the only beneficiaries of that result would be a few special interest groups and third party payors.

What may be most significant to the Federal government, however, is that this legislation would place those states with freedom of choice laws in the precarious position of having to maintain a "two-tier" system. That is, it would be necessary for a state to administer its Medicare and Medicaid programs through separate, though parallel, structures because Medicaid would continue to be governed by state law. Obviously, such a system would be both costly and bureaucratically inefficient for the state. But more importantly, it would be inconsistent with the express purpose of this bill.

MEDICAL EDUCATION

There is one other recommendation of the Advisory Council on Social Security which we would like to address at this time. The Advisory Council recommends that costs for the training of medical personnel should be provided by sources other than the Medicare program. We oppose this recommendation.

Presently, Medicare pays for medical education in two specific ways: a pass-through for direct costs such as salaries, stipends and space; and an indirect cost adjustment based on the ratio of hospital interns and residents to the number of hospital beds. Clearly, there is recognition of the fact that the operation and finances of a hospital are significantly affected by its teaching programs.

We will focus on two issues in our testimony. First medical education is becoming broader as technology and our population changes. Teaching hospitals, especially in terms of their attention to the behavioral and psychological aspects of illness, reflect and reinforce these changes. Our second issue is that nonphysicians are involved in medical education and that this involvement is affected by Medicare. The medical education payments clearly influence the ability of teaching hospitals to deliver a broad range of health services. They help pay the extra costs due to greater severity of illness and necessary special staffing patterns that occur in teaching hospitals. What these payments do not reflect, and what the Medicare program itself does not recognize, is the role of nonphysician clinical faculty in this training process.

We believe that neither the direct medical education payment, now a pass-through in the Medicare Prospective Payment System (PPS), nor indirect teaching cost adjustments to the PPS rate, should be changed without serious consideration of how these changes might affect services offered by teaching hospitals, and the scope of medical education in this country. Proposals to support the direct medical education payment through a separate budget category for health professions training puts this important educational function at risk, and violates the principle that medical education and clinical care should be integrated. Even greater uncertainty, however, is attached to the potential impact of the indirect cost adjustment as administrators and health care professionals attempt to anticipate the complex effects of a DRG system that provides incentives for surgical and procedure based services rather than diagnostic judgment and non-surgical care.

We should clarify for the Committee that the over 900 psychology interns currently in medical schools and affiliated teaching hospitals receive no support under either the direct or the indirect teaching cost payment provisions of Medicare. Nor are psychology interns included in the intern-to-bed ratio for the purposes of the indirect payment calculation. If the intern-to-bed ratio is to be used as a proxy for the illness severity found in teaching hospitals, (and illness severity as well as training needs are a special feature of teaching hospitals), than all post-doctoral clinical interns should be included. We suggest that any changes in the payment structure incorporate attention to this issue.

Further, if Medicare continues its support for medical education, some provision clearly needs to be made for nonphysician medical school faculty and their clinical services to guard against the elimination of their valuable role value in medical school curriculum.

There is considerable concern regarding how hospitals will respond to the fiscal pressures generated by the Medicare prospective payment system. One possible out-

come that is being borne out by preliminary data is that hospitals will discharge patients sooner. Ancillary services will be reduced to cut costs. Hospitals will de-emphasize treating certain categories of patients, or prefer to treat those whose diagnosis renders them eligible for the highest possible reimbursement rate. "Outlier" cases, those that cost more or stay longer than the Diagnosis Related Group algorithm allows, will cause the hospital to lose money. "Inliers," those that cost or stay within the limits assigned to the DRGs, will enable the hospital to make money. The balance between these two categories of patients is what a hospital will closely monitor, or should, to enable it to survive fiscally.

The question for teaching hospitals is whether the higher rate of outlier cases will be sufficiently compensated for by the profit performance of the inliers and the direct and indirect cost adjustments. The available evidence, though sparse, raises legitimate concerns that these costs may not be covered. A recent study at Stanford University Medical School reported that, after adjustment for diagnosis, cost were still eleven percent higher in the faculty service than in the community service of the hospital. However, the mortality rate was significantly lower, especially for patients in the high-death-risk category. This is surely an appropriate trade-off.

In a teaching hospital, balance and comprehensive services must be maintained to accommodate the medical curricula. Achieving the balance necessary from a fiscal point of view is thus more difficult. There is concern that medical/surgical procedures will be increased at the expense of other services and lead to a forced redistribution of available services. Furthermore, many teaching hospitals have a closed staff system and rely heavily on non-physician specialists. A 1983 study from the Institute of Medicine (Personnel Needs and Training for Biomedical and Behavioral Research) states that Ph.D.s accounted for more than 15 percent of clinical department faculty in medical schools in 1982. The reasons these unique staffing patterns are relevant to this are the following:

1. The use of non-physicians permits lower cost augmentation of the available physician pool;
2. There is greater emphasis on psychological and behavioral services in addition to biomedical in a teaching hospital; and
3. Multidisciplinary team approaches that incorporate both of the features have become standard treatment patterns in many teaching hospitals.

Teaching hospitals have a strong emphasis on psychological as well as biomedical treatment procedures, and recognize the value of psychological services in conjunction with biomedical care. There is a considerable body of research literature documenting that when psychological aspects of care are incorporated, length of stay is decreased, recovery is hastened, and patient adherence to treatment regimen is promoted. It is notable that much of the research that has been done in this area took place in teaching hospital settings.

The teaching focus attempts to accommodate a complete approach to health care; its purpose is to educate physicians and other health care professionals in the broadest possible sense. A report just releasd by the Association of American Medical Colleges stresses that medical education programs need to change so that physicians are better equipped in the attitudes and skills of a "caring profession." The use of multidisciplinary teams and psychiatric/behavioral sciences linkages to medical/surgical units are major features of most teaching hospitals and play an essential role in the development of these professional attributes.

The broad relationship between health and behavior has received increased attention in recent years, especially since the 1979 Surgeon General's report "Healthy People." The report stated that seven of the ten leading causes of death in the U.S., are in large part behaviorally determined. As a result, most medical schools have devoted serious attention to health and behavior in their curricular design. At the University of Washington, for example, two years of pre-clinical courses in behavioral sciences are required of all students. The National Board of Medical Examiners examination, which all physicians must take in order to practice, includes a section on behavioral sciences. Psychologists who are faculty in medical schools play a key role in this aspect of the medical school training. The Association of Medical School Professors of Psychology estimates that there are about 3,500 psychologists on the faculties of most of the nation's 128 medical schools.

There is another aspect of the Medicare program that directly affects the ability of nonphysicians to participate in medical education. A common arrangement with medical school faculty members is a provision in their contracts to generate clinical fees. In the past, this was the primary way all medical school faculty were paid, but in recent years medical schools have received funding from other resources, including state and federal monies. The prospect for nonphysician clinical faculties to

maintain revenues from fee income is problematic due to the unintended consequences of the PPS system

The PPS system requires that all services provided for hospital patients must be billed for by the hospital. Separate billing is no longer allowed for any hospital services, except those personally delivered by physicians. The intent of the prospective reimbursement legislation was, we understand, to give hospital administrators more authority over services for which the hospital will be held fiscally responsible. Before prospective payment, psychologists were allowed to bill through a physician under Part B of Medicare (medical and related services) for services delivered to hospital patients. This is no longer the case. Now psychologists are dependent on the hospital administrator to determine whether and to what extent their services will be recognized under PPS. It is under this mechanism that psychologists who are medical school faculty find themselves in a unique position. In effect, PPS jeopardized the ability of medical colleges to continue funding psychologists' faculty salaries, when such salaries are dependent upon income from clinical fees. The Medicare payment system effectively shifts the fiscal authority for psychologist faculty members from the dean of the medical school to hospital administrators.

Full-time regular medical school faculty members, by they physicians or psychologists, are not employees of the hospital but are employees of the University. Our point is that psychology faculty paid by the University and teaching under its responsibility, is suddenly susceptible to control by the hospital administrator under PPS.

The Health Care Financing Administration (HCFA) insists that the costs of a medical education program operated by "another institution" be "borne by that institution and not by the hospital." The PPS makes it necessary that the clinical services of nonphysician medical school faculty be paid by the hospital. To that extent, the hospital is required to pay for, and absorb, the cost of medical education. Given the cost constraints imposed upon hospitals by the Medicare plan, it is extremely difficult, if not impossible, for hospitals to assume added faculty costs. It is highly likely that positions for programs depending on clinical fees from psychologists are in jeopardy.

The Medicare prospective payment plan thus puts at risk the teaching of behavioral sciences in schools of medicine, must of which is conducted by psychologists on the faculties of schools of medicine. It also puts at risk continuation of nationally recognized clinical services, many of which use the latest concepts in behavioral medicine, and many of which are administered, developed, or staffed by faculty psychologists.

It is important to emphasize that this is an issue of concern for medical schools in general. It affects the quality of medical education, the quality of medical care, access to medical care, and goes beyond any specific guild concern psychologists may have.

Thank you for this opportunity to present our views.

STATEMENT OF JOHN DECONCINI, INTERNATIONAL PRESIDENT, BAKERY, CONFECTIONERY & TOBACCO WORKERS INTERNATIONAL UNION

The Bakery, Confectionery & Tobacco Workers International Union, represents over 160,000 workers in the United States and Canada.

Our Union supports the Social Security Advisory Council's minority report, or, the views of Stanford Arnold and Alvin Heaps. Specifically, the BC&T is very much opposed to the earmarking of increased taxes on alcohol and tobacco to increase revenue for Medicare.

Alcohol and tobacco are already two of the most highly taxed commodities in the United States; indeed, excise taxes on cigarettes constitute close to 40 percent of their retail price nationwide, and in some states 50 percent.

There is a limit to the tax burden these industries can face. The 100 percent increase in federal excise tax on cigarettes—from 8 cents to 16 cents in January 1983—yielded only 70 percent increase in revenue in the first quarter of that year. Other nations and many U.S. states have adopted major excise tax increases only to find sales off and revenues far lower than predicted.

Simply put, excise taxes do not provide stable funding. With increases in the federal excise on alcohol or tobacco, (and increases seem likely) revenues from these sources would remain relatively flat or increase only slightly over time. And in theory, with a substantially large increase, it is conceivable that revenues would even drop.

We are talking about financing one of the most important social programs in our nation's history. The actions Congress takes will affect some 26 million elderly and 3 million disabled Medicare beneficiaries—not to mention the future of health care in this country. It would be neither fair nor wise to finance such essential efforts with unstable revenues provided by excise taxes. As trade unionists, we would find this unconscionable.

In addition to being poor revenue raisers, excises on alcohol and tobacco are regressive taxes which disproportionately impact low income and working people. An examination of the cigarette excise reveals that the tax burden—the percent of income taken by the tax—falls drastically as income increases. The effective tax rate on individuals in lower tax brackets is ten times as high as that paid by individuals who earn in excess of $50,000 per year.

The unfairness of the cigarette excise is even more evident when smoking among races and occupational groups is examined. According to recent studies, blacks are more likely to smoke than their white counterparts and persons in occupations traditionally classified as blue collar are more likely to smoke than persons working in jobs classified as white collar and professional.

Cigarette excise taxes are borne more by low and moderate income people than upper income people. Any increase in tax rates will simply exacerbate this already unfair situation and tend to make the overall tax burden fall more heavily on those who are least able to afford it.

If Congress chooses to fund Medicare through the earmaking of excise taxes, it will be doing so at their expense.

Parenthetically, there are those who will argue that the heavier burden excise taxes place on workers and low income smokers will provide them with a greater incentive to quit. This may be true. If it is, however, it again points out the lack of reliability of cigarette excise taxes as a revenue source.

There is no simple answer to the Medicare problem. But two considerations should be paramount in devising any tax that might become part of the solution. One, the tax revenues that are raised should be steadily increasing in future years and should be reliable. Two, the tax should be fair—based on an individual's ability to pay.

Excises on products such as alcohol and tobacco fail miserably on both accounts.

Thank you for your time and consideration.

STATEMENT OF HON. LINDY BOGGS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF LOUISIANA

Mr. Chairman and members of the subcommittee, one of the major issues facing us during the 98th Congress is the rate of increase in the Medicare program, which threatens our ability to continue to provide necessary quality medical care for the Nation's elderly and disabled people. Although the prospective payment system has initiated important cost savings for Medicare in hospital settings, there is an equal need to promote the delivery of health care services in less costly community settings. A bill I have introduced, H.R. 2116, and its companion in the Senate, S. 1615, would provide occupational therapy coverage for our elderly outside of the hospital in skilled nursing facilities, rehabilitation agencies, and outpatient clinics.

Patients in skilled nursing facilities are frequently switched to Part B Medicare coverage when their Part A benefits are exhausted. When this occurs, occupational therapy is no longer covered, treatment is discontinued, and the patient's progress towards recovery and independence is seriously jeopardized. Since occupational therapy can often make the difference between continued institutionalization and discharge to home, it is crucial that reimbursement be available throughout the nursing home stay.

With the prospective payment system, many patients are returning home from the hospital in more acute stages of illness, needing rehabilitative services such as occupational therapy. By providing occupational therapy in less costly community settings close to home, patients can continue their progress towards functioning independently. Occupational therapy in an outpatient clinic or at a rehabilitation agency, such as Easter Seal, generally costs $15–27 less per hour than in a hospital outpatient setting.

Recurring disability and rehospitalization can be avoided when medically necessary rehabilitative services are provided to people who have suffered a stroke, heart attack, or serious physical injury. If rehospitalization of only one percent of the 618,000 elderly stroke victims discharged yearly from hospitals is avoided through

the provision of occupational therapy and other rehabilitation services, Medicare would save nearly $26 million.

The Congressional Budget Office (CBO) estimate of $10–14 million for H.R. 2116 does not include any projected savings from providing occupational therapy in alternative community settings, nor does it include the cost of continued hospitalization for individuals who could be helped to live at home. Studies have shown that after receiving treatment, including two hours of daily occupational therapy, both multiple sclerosis and stroke patients have significantly improved in their ability to return home and care for themselves. Dramatic decreases, from $26,000 to $10,500, in the cost of care for the multiple sclerosis patients were reported. Twice as many of the stroke victims were able to live independently at home after treatment, offsetting the cost of intervention.

I firmly believe we should take a close look at the cost saving possibilities in providing occupational therapy services in community settings. Even beyond the fact that Medicare beneficiaries would benefit by occupational therapy services, the possible cost savings are just too good to overlook.

STATEMENT OF ALAN MEYERS, M.D., BOSTON CITY, HOSPITAL, DEPARTMENT OF PEDIATRICS

Mr. Chairman, the United States is the only country in the industrialized world, East or West, that does not provide some measure of access to health care for all its residents (unless one considers South Africa an industrialized nation, in which case it shares this distinction with the U.S.).[1] 25% of the people of the U.S. (up from 15% in 1974), 51% of Blacks, and 69% of Hispanic people in the U.S. report problems in having enough money to pay for their medical cares.[2] In March 1983 the President's Commission for the Study of Ethical Problems in Medicine reported that in 1982–3, 34 million people were without any health insurance for all or part of the year. In May 1983, the Congressional Budget Office reported that 18 million people in the U.S. lack health insurance solely because of unemployment. Only 33% of those with incomes below 125% of poverty level are covered by Medicaid, while 27% have no health insurance of any kind; overall, Medicare pays only 44% of the total medical expenses of the elderly.[1] Preventive medical services are similarly inadequate, with deteriorating coverage in prenatal care and immunizations, to name two areas of great public health importance. "A moderately effective preventive programme could save 400,000 lives, 6 million person-years of life, and more than 6% of the total health spending each year in the USA, according to a conservative estimate." [1]

The human cost of our government's disregard for the uninsured can only be guessed at, but is undoubtedly enormous. A recent study published in the New England Journal of Medicine [3] documented a 40% increase in the relative risk of death for a sample of medically indigent hypertensive patients who were followed up six months after losing their Medi-Cal (California Medicaid) benefits, compared to controls.

This is a national disgrace.

The issue of the right of the people of the U.S. to universal, guaranteed access to high quality, appropriate care is one of great interest, and has much support, among the general public. Opinion polls indicate that three-fourths of the U.S. public believes that fundamental changes are needed in the nation's health-care system [2, 4] and 59% favor some form of National Health Insurance, even if coupled with a tax increase to pay for it.[2]

Physicians' organizations have historically stood in opposition to social movements for reform of the health care system aimed at improved access, such as Medicare. Such changes have been the result of legislation impelled by a broad social movement. 61% of the general public favors government price controls on doctors' and hospital bills, while 85% of physicians surveyed oppose such controls.[4] Thus, it is reasonable to conclude that future changes guaranteeing universal access will not result from the initiatives of organized medicine, but must be forced upon it by legislative action. ". . . studies show that in areas such as medical care, in which any major national decision will affect the lives of millions of Americans and their families, public opinion is likely to set the practical and political boundaries within which the nation's decision makers can make acceptable changes." [2]

As a physician working in the public sector, I feel that what is needed is a National Health Service, such as the United States Health Service proposed by Congressman Ronald Dellums, as opposed to, e.g., National Health Insurance, because the latter, while an improvement over the current situation, would essentially leave the current system intact and would simply guarantee third-party payment. A funda-

mental restructuring is necessary, and a National Health Service would be a first step toward removing profit as a determinant of health care.

I share the widespread revulsion towards doctors "more concerned with personal wealth than public health"; 66% of the public surveyed feels that doctors are too interested in making money, 68% that physician fees are not usually reasonable, and 62% that physicians do not spend enough time with their patients.[2] This is the natural and predictable outcome of a system which provides such disproportionate financial gains to many physicians in the context of a society such as ours that applauds the acquisition of wealth and power. I am similarly concerned with the huge debts many of us face when beginning the practice of medicine due to the spiralling costs of medical education. A National Health Service which paid a reasonable salary to persons on entry to medical school and for the remainder of her/his professional life would go a long way toward eliminating these problems. I do not share the cynical belief that it is necessary to promise enormous financial gain in order to attract qualified persons to the practice of medicine. If humanistic (as opposed to profit-oriented) physicians are what the people of the U.S. want, then they must create a system which will attract just such individuals and provide them with the means to realize the goals of good, humane, accessible health care for all.

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COMPREHENSIVE CARE CORP.
Newport Beach, CA, September 27, 1984.

Hon. ANDY JACOBS, Jr.,
Chairman, Subcommittee on Health, House of Representatives, Longworth House Office Building, Washington, DC.

DEAR MR. JACOBS: Congress recently raised the excise tax on distilled spirits as part of the Deficit Reduction Act of 1984. We urge that it also raise taxes on beer and wine. The revenues could help offset the projected Medicare deficit and assist the elderly and disabled suffering from chemical dependencies.

For more than a decade, Comprehensive Care Corporation has provided quality treatment programs for alcoholics and their families. We treat some 40,000 chemically dependent individuals annually. We know that elderly alcoholics can be treated and live productive lives, but few of this country's estimated 3.8 million elderly alcoholics receive help because of financial barriers. The Advisory Council on Social Security has stressed that at least $200-$300 billion in additional income or decreased outlays will be required to keep Medicare's trust fund solvent through 1995. Continued decreases in outlays will only erect higher financial barriers for Medicare patients.

Raising federal excise taxes on all forms of alcohol beverages to help keep Medicare in financial health is sound public policy:

Alcohol taxes are primarily user taxes—50 percent of alcohol is consumed by 10 percent of the population.

The Congressional Office of Technology Assessment noted that "alcoholism plays a central contributory role in a variety of ailments that affect the elderly, particularly cardiovascular disease, gastrointestinal problems and cancer."

Alcoholism was the 18th most frequent discharge diagnosis in a 20 percent sample of Medicare patients. And the impact of alcohol abuse is much greater. The American Hospital Association notes that 50 percent of all hospitalizations are alcohol- or drug-related.

It is illogical to increase taxes on distilled spirits and not beer or wine. The amount of alcohol is the same in a 12 ounce glass of beer, 3 ounce glass of wine, or 1 ounce glass of liquor. Many of the alcoholics we treat were primarily drinkers of beer or wine rather than distilled spirits. Also, a 1983 Gallup Poll showed nearly half of all Americans support increased taxes on beer and wine as well as alcohol.

We urge your committee to recommend increasing the taxes on beer and wine as one way to preserve Medicare upon which some 30 million depend for their health care.

Cordially,

EDWARD J. CARELS, Ph.D., *Executive Vice President.*

STATEMENT OF HON. RONALD V. DELLUMS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Chairman, thank you for the opportunity to offer testimony on behalf of the National Health Service Act, H.R. 3884. I first introduced a bill to create a national health service in 1975 and have introduced similar legislation in each succeeding Congress.

H.R. 3884 is co-sponsored by 10 of our colleagues and its principles have been endorsed by, among many others: the American Public Health Association; Physicians Forum; American Medical Students Association; National Medical Students Association; National Association of Social Workers; Gray Panthers; Operation PUSH; DSA; National Women's Health Network; Rural America; Fur, Leather, and Machine Workers Joint Council; and United Electrical, Radio, and Machine Workers.

Mr. Chairman, many Americans with access to high quality care, such as Members of Congress and the Administration who already have their own special health services (eg. the House, Senate, and President's physicians, Walter Reed, Bethesda, etc.) believe that our population is already well served with quality health services. Unfortunately, the reality is quite different.

The present health care system, which is based on the private delivery of health care, financed largely on a fee-for-service basis, and where both the quality and quantity of care is too frequently a function of race, age, income, language, or national origin, does not meet the health care needs of this country.

The problem is not only financial, presumably the principal focus of this hearing. Equally important, there is a serious inequality in the access to services, in the geographical distribution of manpower and facilities, and in the quality of care. In addition, our level of health, as measured by various health indicators, is abysmal for a country as rich as our own.

Mr. Chairman, the United States is the only industrialized nation, with the exception of South Africa, that does not have a national health program for its people. The U.S. now ranks far below most of these countries with regard to major health indicators: 11 nations have lower infant mortality rates; 14 nations have longer life expectancy rates for both men and women; 26 nations have lower cardiovascular death rates; and 12 nations do better in preventing cancer deaths.

Despite our relatively poor performance, we spend enormous amounts of money. We spend some 10 percent of our GNP on health care. This compares to the less than 6 percent spent by the British, and their spending includes a national health service for all the people of their country. It is interesting to note that they also rank higher than the United States in all of the above categories.

Mr. Chairman, we must change the current reality where access to quality health care is often the privilege of the few. Quality health care should be a right of all people and not simply a commodity to be bought and sold in the marketplace.

Why a health service?

Some of the health service financing proposals would most likely improve the present situation. No insurance plan, however, will assure that health services are available to everyone, improve the quality of services, or hold down costs.

Instead of propping up an inadequate system with complex payment mechanisms and ineffective quality reviews, we need a health care delivery system that would provide comprehensive services to all and would be accountable to those it serves.

Mr. Chairman, in my view, any scheme short of this can, at best, only ameliorate the ailments of the present system. No matter how much we guarantee the payment of services, this gives little comfort to people if sufficient services are not being provided.

Mr. Chairman, what distinguishes my proposal from other alternatives is that I disagree with the idea that the American people can have real access to quality health care without changing the structure of the health system.

I disagree that you can simply tinker with the financing mechanisms in an essentially private health care system and expect it to meet the needs of the American people.

It is my view that only through the creation of a national health service can we confront the present crises and assure that services: are actually available to people in every community; are designed to meet the needs of those communities; are oriented not only towards treatment, but to prevention in the broadest sense of that term; and are conducted with the objective of providing service and not profit.

Only such a system can hold down the escalating costs of health care, assure access to health services in every community, and address the increasingly severe occupational and environmental health problems facing the American people.

Let me emphasize, Mr. Chairman, since such a system would serve the needs of all of the people—and not simply the poor, the minorities, and the powerless in our society—it would not be vulnerable to the kind of attacks that have recently been launched against our present public sector health services.

In short, creating a national health service is the only way to provide quality health care for all Americans at a price that this country can afford to pay.

Mr. Chairman, I urge you and your subcommittee to consider such an alternative system and to read the summary, and the Section by Section analysis, of the legislation that I would ask be inserted into the hearing record at this point.

QUESTIONS AND ANSWERS ON THE HEALTH SERVICE ACT (H.R. 3884)

What is the United States Health Service?

The United States Health Service is an independent federal agency that is democratically controlled to deliver health care in communities throughout the United States.

The United States Health Service will provide without charge, a full range of medical, dental, and mental health services, as well as occupational, home health, and health education services. Drugs and medical equipment will be furnished without additional charge.

These services will be provided through facilities established and maintained by the Service. Reimbursement for services provided elsewhere will not be provided, except for emergency conditions.

All health workers will be salaried at levels commensurate with job requirements and their experience.

What will be the Structure of the United States Health Service?

The Service will be set up as a four tier system: community, district, region, and national levels. The "community", a geographic area of between 25,000 and 50,000 (depending on whether urban or rural and other special circumstances), is the fundamental unit of the system.

Several communities will be joined together to form the "district". Each "district" will have a general hospital.

Several "districts" will be joined together to form the "region". Each "region" will have a medical center providing highly specialized medical services and a health team school, where all health care workers will receive their education.

How will the System be Run?

Community Health Boards, chosen in community-wide elections by residents and health workers, will plan the delivery of primary and preventive health services. The Boards will also hire community health workers and assume overall responsibility for all community health services.

District Health Boards, appointed by the Community Boards in each District, will oversee the District general hospital.

Regional Health Boards, appointed by the District Boards in the Region, will oversee the Regional medical center and Health Team schools, and will assist the Community and District Boards in performing their functions.

The National Health Board, appointed by the Regional Boards with the approval of the President, will carry out overall planning and budgeting and establish guidelines for the provision of health services by all health Boards.

How will the Quality of Health Care be Assured?

In contrast to the present licensing system, this Act calls for continuing review and assessment of the competency of health care providers, with oversight by user-, as well as provider-, representatives. The National Board will establish national guidelines for the various Boards for the training, hiring, and certification of health workers.

The ultimate safeguard of quality is the control of service delivery by Health Boards accountable to those who use the services and those who work in it, able to draw upon all of the professional expertise employed by the Health Service for advice and technical support.

How will the Service Address the Present Maldistribution of Resources?

Operating funds will be allocated to Regions, Districts, and Communities on a per capita basis. This will allow currently underserved areas to overcome their present serious shortages of health workers, facilities, and other resources. Additional resources will also be allocated to communities with special health care needs, such as areas with larger populations of elderly or low income people.

The present maldistribution of health workers will be addressed by having graduates of the Health Team Schools serve in underserved areas for a two year period, and by requiring that Boards not hire particular health worker classifications in excess of specified maximum provider per population ratios.

How will the Service be Financed?

Despite the expansion of services, the cost of operating the Service will be substantially less than the cost of the present health care system. The elimination of administrative costs associated with the insurance industry and its complex billing procedures, the decrease in unnecessary hospitalization and treatment from the elimination of fee-for-service medical practice, and the elimination of excessive fees and profits, are estimated to reduce the total cost by at least 20 percent.

Funds to operate the Service will come from a Health Service Trust Fund containing receipts from a special Health Service Tax on individuals and employers and a General Fund contribution based on the Health Service Tax. The Tax will be progressive and lower income taxpayers will pay less than they presently pay for the Medicare Trust Fund tax. Since the Service will provide services for all persons, the Medicare tax will be repealed as will employer deductions for employee health benefit contributions.

PROBLEMS

1. Health care in the U.S. is very expensive.—Americans pay more for their health care than people in any other country—over $1,100 per person per year. Doctors sometimes charge over $1,000 for operations that take less than one hour to perform. Even the natural act of having a healthy baby can cost a family more than $2,000. Despite all the money we spend on medical care, the chances of a baby dying before its first birthday are higher in the U.S. than in other industrialized countries.

2. Health insurance is incomplete.—27 million Americans have no health insurance at all. Those who do are often surprised to find their policies won't cover the whole bill. Medicare was supposed to protect the elderly against the ravages of high medical costs, yet in 1978 our senior citizens paid $862 or 43% of their health care costs themselves. In general, Americans pay one-third of all medical and dental bills directly out of pocket. Doctors often charge hundred of dollars more than the insurance company will pay; drugs and office visits are rarely covered; the bills add up. And if you lose your job, you usually lose what little coverage you had. Medical bills are now the number one cause of family bankruptcy in the U.S.

3. High quality personal care is hard to find.—Anyone who has travelled for miles, to wait for hours, to spend minutes with a doctor who didn't answer your questions knows that personal care is hard to find. Since physicians and hospitals tend to be concentrated in affluent areas, many rural and inner city residents are left without convenient facilities. Most doctors today are trained as specialists and are often more interested in fancy lab tests than in talking things over with the patient.

4. There is little emphasis on prevention.—Our current medical system is geared toward treating medical emergencies rather than preventing those emergencies from happening. For example, insurance often pays for the radiation therapy to slow down a woman's cervical cancer, but not for the pap smear that would have detected it at a curable stage. Policies will cover the hospital bills for our sick children, but not the vaccines that would keep them from getting sick in the first place. Although our health system will treat the worker made ill by dangerous chemicals or unsafe machines, there is little emphasis on preventing injuries in the workplace.

5. We have little control over our health services.—Doctors, hospitals and clinics arrange their services with an eye towards their own profit and convenience. Few offices stay open late, so you often have to lose a day's pay to be seen. While our tax dollars pay an increasing share of health care costs, we have little voice in deciding what services should be provided, where they should be located, or when they are available.

SOLUTIONS

1. The health service will decrease total health care costs.—It is estimated that the proposed comprehensive Health Service program would cost 20-30% less than we

now spend on health care. The administrative, advertising and billing costs of the insurance and drug companies, which are passed on to us under the present system, will be eliminated. Preventive office visits and home care will reduce the need for hospitalization and thus lower costs. Just as the public hires police, fire-fighters and teachers, we will hire doctors and other health care workers at reasonable salaries, eliminating excessive fees and profits.

2. There will be no financial obstacles to health care.—Any person in the U.S. will be eligible to receive complete health services. There will be no deductibles, no coinsurance, no personal billing. The money to run this program will come from a progressive income tax, a corporate profit tax and general federal revenues. Most people will pay less for health care than they do today.

3. The health service will assure high quality care.—Communities will receive funding in proportion to their population and special needs. Each community will establish health facilities, hire the necessary health care workers and review the quality of their work. Individuals will have the freedom to choose their personal physicians and other health professionals from among those in the local area, or in any area they choose.

4. The Health Service will emphasize prevention.—Funds will be available for identifying and correcting the social, occupational and environmental causes of illness, injury and death. Regional occupational safety and health programs will be established. Routine screening will detect illnesses before they become medical emergencies. Health education will be emphasized; promoting good health habits will reduce the incidence of disease.

5. The Health Service will be controlled by those who use it and work in it.—All levels of the U.S. Health Service will be run by the elected health boards composed ⅔ of consumers and ⅓ of health workers. Community boards will organize and run local health facilities. They will select members of the district boards to oversee general hospitals. District boards will select representatives to regional boards, which will oversee special care facilities and schools for health workers. The national health board, selected by the regional boards will set national health policy, determine the overall health budget and distribute funds to each level.

National Health Service Act, H.R. 3883

SECTION-BY-SECTION SUMMARY

TITLE I—ESTABLISHMENT AND OPERATION OF THE UNITED STATES HEALTH SERVICE

Initial operation

Sec. 101—Establishment of the Service. There is established an independent establishment of the executive branch to be known as the United States Health Service. The authority of the Service shall be exercised by the health boards set up under this Act.

Sec. 102—Appointment of Interim National Health Board. No later than 30 days after the enactment of this Act, the President shall appoint 21 individuals over 18 years of age, broadly representative of the Nation's population, and no more than 7 of whom have been health workers within the preceding 2 years, to serve as members of the Interim National Health Board.

Sec. 103—Powers and duties of the Interim National Health Board. Members of the Interim National Health Board shall take whatever steps are necessary to establish the Service. They shall serve as the National Health Board of the Service until the National Health Board holds its first meeting, establish boundaries of health care delivery regions, select and provide assistance to interim regional health boards, and coordinate the initial election of community health boards.

Sec. 104—Authorization. There are authorized to be appropriated to the Service $4 billion to establish the Service.

Organization of area health boards

Sec. 111—Establishment of health care delivery regions. No later than six months after the appointment of members of the Interim National Health Board, the Board shall establish health care delivery regions throughout the United States. Each health care delivery region shall be a contiguous geographic area having a population of not less than 500,000 and not more than 3 million, except that the population may be less than 500,000 if it would facilitate the delivery of health care services or the effective governance of the program, and it may be greater than 3 million if the region includes a standard metropolitan statistical area. The boundaries of such re-

gions shall consider economic and geographic barriers to the receipt of health care in nonmetropolitan areas. At least 60 days prior to the establishment of a boundary, the Interim National Health Board shall provide for a public hearing regarding such boundary.

Sec. 112—Appointment of interim regional health boards. No later than 60 days after the establishment of health care delivery regions, the Interim National Health Board shall appoint an interim regional health board for each region. Each interim regional health board shall be composed of 9 members over 18 years of age, broadly representative of the region's population, and no more than 3 of whom have been health workers within the preceding 2 years. Each interim regional health board shall establish the boundaries of health care delivery districts and communities in its region and conduct elections for voting members of community health boards in its region.

Sec. 113—Establishment of health care delivery districts and health care delivery communities. No later than six months after its appointment, each interim regional health board shall establish health care delivery districts and communities throughout its region. Each region shall be divided into three or more districts, each of which shall be a contiguous geographic area having a population of not less than 100,000 or more than 500,000, except that a district may have a population of less than 100,000 if this would facilitate the delivery of health care of the effective governance of the program.

Each district shall be divided into three or more communities, each of which shall be a contiguous geographic area whose residents have a commonality of interest, language, and ethnic and racial composition and whose population is not less than 25,000 or more than 50,000 except that a community may have a population of less than 25,000 if this would facilitate the delivery of health care or the effective governance of the program.

At least 60 days prior to the establishment of a boundary, the interim regional health board shall provide for a public hearing regarding such boundary.

Sec. 114—Election of community health boards. The Interim National Health Board shall arrange with State and local governments for the initial election of user members to be held on a date not later than 9 months after the appointment of the interim regional health boards. For each board there shall be 6 user members, plus one user member for each 5,000 residents in the community in excess of 30,000. For each board there shall be 3 worker members, plus one for each 10,000 residents in the community in excess of 30,000. The Interim National Health Board shall establish procedures for nomination and election of these health board members following the criteria outlined in this Act. The interim regional health boards shall conduct and supervise the nominations and elections of community health board members.

The initial meeting of each community health board shall be held not later than 30 days after the election.

Sec. 115—Appointment of district health boards. Not later than 60 days after its initial meeting, each community health board shall appoint two users residing in the community to serve as user members of its respective district board. The worker members of each board shall appoint a community health worker to serve as a worker member of its respective district board. The district health workers shall appoint a district health worker to serve on the district health board following procedures outlined in the legislation. The initial meeting of the district health board shall be not later than 30 days after such appointment.

Sec. 116—Appointment of regional health boards. Not later than 60 days after its initial meeting, the user members of the district health board shall appoint two users to serve as user members of its respective regional health board. The worker members of the district health board shall appoint a district health worker as a worker member of its respective regional health board. The regional health workers shall elect a regional health worker to serve on the regional health board. The initial meeting of the regional health board shall be not later than 30 days after such appointment.

Sec. 117—Appointment of the National Health Board. Each region shall be assigned to one of three groupings of regions, each having (to the extent possible) an equal number and balanced geographic distribution. Each board for a region in the first two groups shall appoint a user to serve as a user member and the National Health Board; the others shall appoint a worker member. These names shall be submitted to the President who shall have 10 days in which to approve or disapprove the nominations.

Sec. 118—Subsequent election and appointment of members of health boards. The next election for members of the community health boards shall be held in conjunc-

tion with each election of Members of the U.S. House of Representatives that occurs after the effective date of health services. The term of service (of all members of health boards) will be four years with staggered terms, half of the members being elected every two years. Such elections, and subsequent appointments of members of district and regional boards and the National Health Board shall conform to the requirements of sections 114, 115, 116, and 117, respectively.

Sec. 119—Modification of the boundaries of health care delivery areas. No later than 2 years after each decennial national census, and at any other time it deems necessary, the National Health Board shall review the appropriateness of the boundaries of each region and may modify the boundaries if there has been a substantial population shift and if the modification is approved by a referendum of the residents whose regional identification would be changed. At least 60 days before the modification, a public hearing shall be held.

No later than 2 years after each decennial national census, upon receipt of a petition signed by not less than 15 percent of the registered voters in an area, and at other appropriate times, each regional board shall review the boundaries of the districts and communities in its region. A regional board may, after review and public hearings, modify a boundary if there has been a substantial population shift or the change would better carry out the purposes of this Act, and if the change is approved by a referendum of those affected by it.

General provisions regarding health boards

Sec. 122—Membership of health boards. Each health board shall be composed of (1) members elected or appointed in accordance with the preceding sections, (2) one member appointed, in the case of a community board, by the community occupational safety and health action council established in section 412 and, in the case of a regional board, by the regional occupational safety and health action council established in section 413, (3) such voting user members as are necessary to ensure that the user members of the board approximate the population of the area by race, sex, income level and language and segments of the population having special health needs, and (4) such nonvoting associate members as the members determine to be necessary to provide representation of State, territorial, and local government, of segments having special health needs of the population and, in the case of the Interim National Health Board and the National Health Board, to help carry out this Act.

A recall election shall be held for any member of a community health board no later than 60 days after presentation to the regional health board of a petition signed by at least 15 percent of the registered voters (or health workers as appropriate) in the community requesting recall of the member. Members of district, regional, and the interim regional boards, and the National Board, may be recalled from office by the vote of two-thirds of the health board which appointed such members.

No individual may serve as a member of any board for more than 4 consecutive years, exclusive of any time that may be served to fill a vacancy. A vacancy caused by the death, resignation, or removal of a member shall be filled with 60 days by the same process which placed the original member on the board.

Sec. 123—Meeting and records of health boards. The members of each health board shall elect a chairperson and vice chairperson from among their members. The chairperson shall be responsible for convening meetings, including upon written request of any two members, and for carrying out other duties as the board may assign. Minutes of meetings of the board and its committees shall be available to the public, and all such meetings shall be open to the public.

Each health board may establish committees and advisory groups, and appoint to them such individuals as they find necessary to carry out their duties. Members of health boards shall receive per diem or salary payments plus reimbursement for necessary expenses.

Sec. 124—Procedures for establishment of national guidelines and standards. The National Health Board shall establish such guidelines and standards as will facilitate implementation of this Act. It encourages innovation and experimentation in achieving its objectives. At least 90 days before establishing a guideline or standard, it shall submit such guidelines or standards to all regional health boards for their review and comment. The National Health Board shall assist members of area health boards in using and implementing such guidelines and standards.

Sec. 125—Assistance to area health board members. Each regional board shall provide orientation, education, and technical assistance to district and community boards to insure that they are prepared to perform their duties.

TITLE II—DELIVERY OF HEALTH CARE AND SUPPLEMENTAL SERVICES

This title specifies the health care and supplemental services, and the administrative arrangements for delivering such services.

Patients' rights in health care delivery

Sec. 201—Basic health rights. The Service, in delivering health care services, shall ensure that every individual is given basic health rights. These include the right to receive high quality health care and supplemental services without charge and without discrimination; to be treated with dignity and respect; to choose health workers and to be responsible for facilities in which to receive service, to have access to one's health records; to have information translated into the individual's primary language; to receive a full explanation of all questions related to health care; to refuse any health care service, when the refusal does not directly endanger the health of others; to have counseling and assistance on health matters; to be accompanied and visited at any time by a friend or relative of the individual in the event of terminal illness, to die with dignity and to be allowed to die at home; and to have access to a complaint system and to legal assistance to enforce these rights.

Sec. 202—Right to paid leave to receive health care services. Each employee is entitled to one hour per 35-hour work week of paid leave to receive health care services.

Eligibility for, nature of, and scope of services provided by the service

Sec. 211—Eligibility for services. All individuals while within the United States are eligible to receive health care and supplemental services under this Act.

Sec. 212—Entitlement to services. On or after the effective date of health services, the Service shall provide users with all health care and supplemental services described in section 213 which are necessary for the promotion and enhancement of health, the prevention of disease, the treatment of illness, and rehabilitation following injury, disability or disease. These services do not include personal comfort or cosmetic services, unless the health board providing the services determines they are needed for health-related reasons.

Sec. 213—Provision of health care and supplemental services. The Service shall provide the following health care services in or through facilities established by the Service: promotion of health and well-being through health education programs; prevention of illness, injury, and death through education and advocacy addressed to the social, occupational and environmental causes of ill health through preventitive services; diagnosis and treatment of illness and injury, including inpatient and outpatient service, mental health, occupational health, dental care, long-term care, and home health services; rehabilitation of the sick and disabled; and provision of drugs and therapeutic devices, appliances and equipment. The Service shall provide supplemental services of transportation and ambulance service to health facilities, child care facilities, homemaking and home health services, and counseling and social service assistance. The Service shall conduct environmental and preventive functions now performed by State and local health departments. The Service shall provide reimbursement for the cost of emergency health care services provided in facilities or by persons outside the Service, when immediate medical attention is required and it is impractical for the individual to receive care from the Service.

Health care facilities and delivery of health care services

Sec. 221—Establishment of health care facilties and distribution of delivery of health care and other services. Each community board shall establish facilities in its community to deliver (1) comprehensive primary medical and dental care immunization, nutrition and screening services; children's health services; obstetrical and gynecological services; family planning and contraceptive services; pregnancy and abortion counseling and services; vision and hearing testing; provision of eyeglasses and other visual aids and hearing aids; 24-hour emergency medical services, provision of pharmaceuticals and medical equipment, mental health services, home health services; (2) specialized inpatient and outpatient health care services when these can be most effectively provided in a community setting; (3) supportive services and facilities for the physically or mentally handicapped, mentally ill, infirm and chronically ill to promote their integration and functioning within the community, and (4) community oriented health measures to focus community activities on the promotion of health and prevention of illness and injury and to make all residents aware of their ability to use the health services.

Each district board shall establish in its district a general hospital to provide inpatient health care services, as well as such other facilities as will promote the effective delivery of health care in its district.

Each regional board shall (1) establish a regional medical facility providing highly specialized health care services, and (2) provide health care services for individuals whose health care needs cannot be met by community or district boards because of occupational or other factors including migratory agricultural workers and those confined to correctional institutions.

Each area health board shall also provide health education, the maintenance of personal health records, referral services to facilties outside the area, assistance to individuals with language or cultural differences or educational handicaps in utilizing the services, information on health rights, guidelines, and standards, information on grievance mechanisms and legal services, and environmental health inspection and monitoring services.

Each area health board shall hire appropriate health workers (including administrative personnel) to ensure that its facilities provide the services mandated for the board. Each area health board shall utilize, wherever possible, existing health facilties including health centers, clinics, hospitals, nursing homes, and medical laboratories.

If a community district board fails to provide the necessary health care and supplemental services on the effective date of health services, its respective regional board shall take whatever steps are necessary to ensure that such services are available to individuals, in the area. This may include appointment to a trustee or trustee committee under section 402, requiring the community or district board in an adjacent area to provide such services on a temporary basis, or (until three years after the effective date of health services) providing reimbursement provision of specified services using procedures in effect just before the effective date of health services under title XVIII of the Social Security Act (Medicare).

Sec. 222—Operation and inspection of health care facilities. Each health board shall establish policies and organizational plans for each facility it has established. In establishing, implementing, and modifying such policies and plans, it shall seek the fullest possible participation of health workers in the facility and individuals using the facility by the workers in the facility. These policies and plans shall provide for (1) the management of the facility through decisionmaking mechanisms which provide full and equal participation of all health workers employed in the facility, (2) the elimination of domination by health professionals, and (3) regular accountability of the health workers to the board which established the facility.

On and after three years after the effective date of health services, a health board may not permit a health facility it has established to be used for the private delivery of inpatient or outpatient services. No individual employed by a health board may engage in the private delivery of health care. ("Private delivery" means the delivery of the services for which there is remuneration from any source other than the Health Service Trust Fund established in section 511.)

Each health board shall ensure that any facility which provides substantial inpatient service for indivduals who are within it for continuous periods of 30 days or longer is cleared and well-heated, cooled and ventilated, adequately staffed, provides, confortable quarters for inpatients, provides opportunities for creative activity and recreation, establishes a review committee, informs an inpatient of all decisions involving the inpatient's health, and permits participation in such decisions. It shall not censor or harass communication of an inpatient, confiscate personal property, deny social and sexual life, require that the inpatient work, pay an inpatient less than the minimum wage, physically restrain an inpatient, other than one convicted of a crime, involuntarily for more than 72 hours without determination by the facility's review committee that such restraint is necessary, or take punitive or discriminatory action without approval of the facility's review committee. Annually, the inpatients of each such facility shall elect, from among themselves and any representatives of an interested user association, a review committee of at least 3 members.

Quality care shall be assured by regular inspections of the health care facilities. The results will be reported to the public.

Sec. 223—Provisions of health services relating to reproduction and childbearing. Area health boards shall provide the following services: complete information on contraception and provision birth control materials or medication of the individual's choosing; complete and effective evaluation and treatment of venereal diseases and diseases of the reproductive organs, complete information and counseling with respect to pregnancy, childbearing and possible outcomes involving genetically induced anomalies; complete and effective pregnancy testing; prenatal services; safe, comfortable and convenient abortion services; counseling by women in conjunction with the provision of all gynecologic, female contraceptive and abortion services and the counseling by men for male fertility-related services.

The services will be delivered without coercion or harassment, with complete confidentiality and without prior approval by anyone other than the individual receiving the services. An individual may be accompanied by a person of the individual's choice during the provision of the services described above to the extent this would not significantly increase the medical risk to the individual.

No area health board may perform a treatment or procedure (other than to preserve the patient's life) which could reasonably be expected to affect the individual's capacity to reproduce children unless the individual has again given voluntary consent to the treatment or procedure after being given full information on the effect of the treatment or procedure and on possible alternative treatments at least 30 days before beginning the treatment; and the individual, after the 30 day waiting period, has given written consent. Exceptions to this are the voluntary sterilization following the delivery of a child written consent has been given 30 days prior to the anticipated delivery date, or during emergency surgery within the 30 day waiting period.

Before a mastectomy or other breast cancer treatment is performed, an area health board shall provide the woman with complete information on the range of medical options available and the side effects of each option and she shall give voluntary written consent to such procedures.

An area health board shall provide that a woman may deliver her infant in her home, be accompanied during labor and delivery by whomever she chooses, use the position she chooses, care for her infant at her bedside, and feed her infant according to the method she desires, and be provided with information on the benefits, risks and side effects of each option.

TITLE III—HEALTH LABOR FORCE

Job categories and certification

Sec. 301—Effect of State Law. Notwithstanding any law of a State or political subdivision to the contrary, the service shall be the sole judge of the qualifications of its employees.

Sec. 302—Qualifications of Health Workers.—Each area health board shall establish procedures which ensure that work classified under a job category is performed by a health worker who is certified as competent to perform the work and authorized to perform the work by the area health board which employs the worker. Each area health board shall provide for the periodic review and assessment of the competency of its employees, and shall provide opportunities for health workers to be certified for more advanced job categories, each regional board shall provide periodic review and assessment of the performance of health workers in their region. The National Health Board shall provide the same for regional health workers.

Sec. 303—Establishment of Job Categories and Certification Standards.—The National Health Board shall establish guidelines for the classification, certification, and employment of health workers by job category that will ensure that health workers have demonstrated the necessary competency, expand the roles of health workers by enabling them to participate in health care delivery to the maximum extent consistent with their skills and permit alternative approaches to healing. In establishing these guidelines, the National Health Board shall provide for sufficient flexibility to permit regional boards most effectively to meet the health needs of their regions, and for sufficient uniformity to permit mobility of health workers among the regions as well as require exchange of health workers between districts. The National Health Board shall periodically evaluate the job categories and certification practices and make whatever modifications it deems necessary.

For job categories not requiring advanced specialty training, each regional board shall establish certification standards for its region which specify the functions performed by a health worker employed in a job category, the skills required to perform this work, the initial and continuing training, experience, and performance required, and the curriculum which a health worker must follow in a health team school. Each area health board within the region shall apply such standards to all health workers it employs.

The National Health Board shall establish standards for job categories involving highly specialized skills and requiring advanced specialty training. Area health boards shall apply such standards to all health workers employed by them in such job categories.

All such standards shall periodically be reviewed and modified as appropriate.

Education of health workers

Sec. 311—Health team schools. Each regional board shall establish a health team school to provide initial and continuing education in health care delivery for all health workers. Each school shall be functioning not later than four years after the effective date of health services, unless the National Health Board approves an alternate plan. A regional board, in consultation with its district and community boards, may decide that conducting particular educational programs in its school would be inefficient or inappropriate, and it may collaborate with one or more adjacent regional boards in conducting joint programs.

Schools shall be funded exclusively by the Service, shall not charge tuition, and shall provide students with allowances for living expenses. The National Health Board shall establish guidelines for operating health team schools such that the activities of each school shall be designed to meet the health needs of the region it serves, the number of students enrolled in each educational program shall be based on the needs of the region, and education for different job categories shall be integrated so as to permit health workers to receive successively higher levels of education. Each school's admissions, curriculum, faculty hiring, and governance policies shall be established with the fullest possible participation of community boards, health workers, staff, and students. Schools may not use low-income or minority individuals, women, or those in mental or penal institutions for experiments and demonstrations in numbers that are disproportionate to their population in the region.

Each regional board shall establish admissions policies for its school which emphasize previous health-related work experience, minimize the use of academic criteria other than those that are significantly related to future work performance, give preference to segments of the population now underrepresented among health workers, seek a student body that approximates the region's population by race, sex, family income, and language, and require the applicant to agree to perform health care service in accordance with Sec. 312.

Each regional board shall establish curriculum policies for its schools that give priority in study and field work to the leading causes of illness and death in the region (including especially environmental and social factors), provide all students with a common initial sequence of courses and then offer progressively more specialized studies, emphasize work-study experience in all types of health care facilities in the region, and facilitate the development of skills in decisionmaking and problem assessment by all health workers.

Each regional board shall establish faculty hiring procedures that seek a faculty that approximates the population of the region, and shall establish a government plan for the school which gives significant decisionmaking powers to staff and students.

Sec. 312—Service requirement. No individual may be enrolled in a health team school unless the individual agrees to perform service as an employee of the Service after graduation, for a period of time equal to the period of enrollment but not to exceed two years and for an area health board with the highest priority. For graduates of a health team school in a particular job category, the priority ranking for hiring is as follows: (1) the region, or a district or a community in the region, in which the school is located, if there is a health worker shortage in that job category; (2) any other region, district or community having such a shortage; and (3) any other area. A health worker shortage is defined to exist if an area has a ratio of the number of health workers in that job category to the number of residents which is less than two-thirds of the average of that ratio in the Nation, and the area health board has plans and a budget which call for hiring such an individual. The National Health board shall assist in matching the locational preferences of graduates with the needs of the area health boards in the area. Any individual who refuses to fulfill his service obligation shall be required to repay to the Service an amount determined in accordance with a formula stated in this Act.

Sec. 313—Payment for certain educational loans. For individuals who have incurred educational loans prior to the enactment of this legislation and who agree to work for the U.S. Health Service, the Service agrees to assume payment of their educational loans in accordance with this section.

Employment and labor-management relations within the service

Sec. 321—Employment, transfer, promotion, and receipt of fees. Health boards shall hire, classify and fix the compensation and benefits of their employees, in accordance with this Act and guidelines established by the National Health Board. There shall be employment and promotion in the Service in the same manner as is provided under the Federal civil service system, opportunities for career advancement, encouragement of health workers to use up to ten percent of their work time

for continuing education without loss of pay, and full protection of employees' rights to a fair hearing on adverse actions.

Health boards shall give preference in hiring to those employed, or self-employed, as health workers before enactment of this Act. The National Health Board shall ensure that all such individuals may find employment within the Service Employees of the Service shall be eligible for promotion or transfer to any position in the Service for which they are qualified. Each regional health board shall have a job placement service to assist health workers in its region in attaining the maximum degree of career promotion opportunities and to insure continued improvement of health care services.

A district or community board may not hire an individual to fill a position in a job category if the ratio of health workers in that category to residents in the district or community is greater than four-thirds of such ratio for the region, and if there is a district or community within the region which is a health worker shortage area.

An employee of the Service may not receive a fee or prerequisite from anyone other than the Service for duties performed by virtue of such employment.

Sec. 322—Applicability of laws relating to Federal employees. The provisions of chapter 75 of title 5, United States Code (relating to adverse actions against employees), subchapter I of chapter 81 of title 5, United States Code (relating to compensation for work injuries), and chapter 83 of title 5, United States Code (relating to civil service retirement) shall apply to employees of the Service (except in some cases for the personal staff of health board members), unless these are inconsistent with provisions of negotiated collective bargaining agreements or with procedures established by the Service and approved by the Office of Personnel Management.

Compensation, benefits, and other terms and conditions of employment in effect before the effective date of health services for health workers employed by the Federal Government shall apply to employees of the Service until changed by the Service in accordance with this Act. No variation of fringe benefits shall result in benefits which are less favorable to employees of the Service than benefits in effect for employees of the Federal Government on the effective date of health services.

Sec. 323—Applicability of Federal labor-management relations law. The provisions of the National Labor Relations Act shall apply to the Service and its employees, except that (1) supervisory employees shall be included (2) professional and unprofessional employees shall not be treated separately and (3) emergency provisions shall apply to regions.

Sec. 324—Defense of certain malpractice and negligence suits. No malpractice suit may be brought against an employee of the Service while acting within the scope of the employee's employment. The remedy in such cases shall be in civil action brought against the United States.

TITLE IV—OTHER FUNCTIONS OF HEALTH BOARDS

Advocacy, grievance procedures, and trusteeships

Sec. 401—Advocacy and legal services program. Each area health board shall establish a program of health advocacy to ensure the full realization of patients' rights. Such program shall include the employment of health advocates in health care facilities and measures to correct any infraction of such rights.

The National Health Board shall establish a health rights legal service program to ensure that patients and health workers receive free of change, high quality legal services for problems related to health care. The health rights program shall include the establishment of a legal services office in each region, and the establishment of such offices in communities and districts that have inadequate legal services. This program may be carried out directly or, in each instance, by contract with the National Legal Services Corporation or members of the private bar.

Sec. 402—Grievance procedures and trusteeships. Any user, health worker, or user association having an interest in health care may commence a grievance proceeding before a regional board, and a regional board may commence such a proceeding before itself, because of an alleged violation of this Act by a district or community board. Any user, health worker, or user association may commence a grievance proceeding before the National Health Board because of an alleged violation of this Act by a regional board, and the National Health Board may commence such a proceeding before itself.

The National Health Board shall review by appeal, by any party or on its own initiative, an adverse decision by a regional board.

Whenever a grievance proceeding is commenced there shall be a public hearing if the grievance is supported by a suitable petition or before setting aside an election

or transferring any function of a board. If a grievance concerns the conduct of a election of a community board, and it is determined that the election was not conducted in compliance with this Act, or that there had been systematic failure of the user members of such community board to approximate the population of the community, by race, sex, language, of income level, the election shall be set aside and a new one held within 60 days after the date of the determination. If a new election is held because of a determination that portions of the population have not been represented, the election shall be conducted in a way that will facilitate such representation.

For grievance having to do with other matters, if is determined that a health board has failed to comply with this Act, a new election or appointment within 60 days may be required. If it is determined that a community or district board has failed to comply with this Act, functions of such board may be transferred to the respective regional board until a new election or appointment is carried out. If a regional board has failed to comply with this Act, functions of this board may be transferred to the National Health Board until a new regional board is appointed.

Any party to a grievance proceeding may bring suit in the United States district court for the judicial district in which such proceeding was brought.

Occupational safety and health programs

Sec. 411—Functions of the National Health Board. On and after the effective date of health services, the National Health Board shall oversee an occupational safety and health program conducted at the regional level and shall participate in establishing and administering occupational safety and health standards under the Occupational Safety and Health Act of 1970, which is amended to transfer this area of authority from the Secretary of Health and Human Resource to the National Health Board.

Sec. 412—Community occupational safety and health activities. A community occupational safety and health action council shall be established in each community as follows: With the assistance of the community board, employees of each workplace in the community having 500 or more employees shall elect one member for each 500 employees; employees of workplaces having less than 500 employees shall vote in communitywide elections for a number of members equal to the number of such employees divided by 500 (rounded to the next highest whole number). Each such council shall appoint one individual to serve as a member of its community board; appoint one individual to serve as a member of the regional occupational safety and health action council for its region; advise the community board on, and oversee occupational safety and health programs in the community; facilitate the establishment and operation of workplace safety and health committees; and assist employees with respect to inspections of their workplaces.

Sec. 413—Regional occupational safety and health programs. Each regional board shall establish an occupational safety and health program for its region using to the maximum extent feasible, facilities and resources of the community boards in its region. This program should include increasing the ability of employees to monitor safety and health conditions in, and assist in inspections of, their workplaces; facilitating communication among workers employed in similar industries in the region and unions regarding occupational hazards; conducting biologic screening of employees; monitoring the environment to identify hazards; and analyzing employment-related injuries and illnesses in the region.

Each regional occupational safety and health action council shall appoint one individual to serve as a member of its regional board, and shall advise its regional board and the National Health Board on occupational safety and health matters.

Sec. 414—Workplace health facilities. The employer in each workplace having 25 or more employees shall maintain a health facility in or near the workplace for occupational and emergency health care for employees. These facilities shall be organized according to National Health Board guidelines to provide services that meet the needs of the employees. They will be operated by the community board or the employer, with the cost in either case borne by the employer.

Sec. 415—Employee rights relating to occupational safety and health. Employees in each workplace having 25 or more employees shall have the right to establish workplace occupational safety and health committees. Members of these committees (not to exceed one for every 100 employees or fraction thereof) may, without loss of pay, spend 8 hours of each month on occupational safety and health matters and may accompany inspectors during inspections of their workplaces. Employees have the right, without loss of pay, to monitor safety and health conditions in their workplaces and to remove themselves from the site of any hazard until it has been eliminated. Employers shall furnish their employees with safety equipment and clothing.

Employees or their representatives shall have the right to inspect all medical records kept by their employer on the condition of their health. Employers shall provide their employees with copies of reports and data on conditions affecting their health and safety and with timely notification of the presence of any dangerous materials or conditions.

Health and health care delivery research

Sec. 421—Principles and guidelines for research. On and after the effective date of health services, the Service shall conduct a program of research on health and health care delivery. Within two years thereafter, the research program shall conform to these principles: (1) to the maximum extent possible, research shall be performed under the direction of, and in association with community, district and regional boards; (2) area health boards must review and approve any research conducted in their facilities; (3) priority in health research shall be given to the prevention and correction of the leading causes of illness and death; (4) priority in health care delivery research shall be given to the improvement of ambulatory and primary health care; (5) no research shall be conducted using human subjects until all useful animal research has been undertaken; and (6) no research shall be conducted on humans without written consent of the individuals or while involuntarily confined.

Sec. 422—Establishment of institutes. The National Health Board shall establish a National Institute of Epidemiology, a National Institute of Evaluative Clinical Research, a National Institute of Health Care Services, a National Institute of Pharmacy and Medical Supply, and a National Institute of Sociology of Health and Health Care, each with specified functions.

HEALTH PLANNING, DISTRIBUTION OF DRUGS AND OTHER MEDICAL SUPPLIES, AND MISCELLANEOUS FUNCTIONS

Sec. 431—Health planning and budgeting. Each area health board shall collect data on the delivery of health care in its area and shall transmit this data and their evaluation of it to the respective regional board, in the case of a district or community board, or to the National Health Board, in the case of a regional board and to residents of the area. Each regional board shall coordinate the planning and administration of health care service, health worker education, and research in its region. The National Health Board shall formulate a national health plan and budget, in consultation with the regional boards, to provide guidance to area health boards.

Sec. 432—Distribution of drugs and other medical supplies. The National Health Board shall prepare and disseminate to area health boards a National Pharmacy and Medical Supply Formulary which will list drugs and medical supplies and give, for each item, standards of quality, medical conditions for which it is certified effective, and other appropriate information. At regular intervals the Board shall update the Formulary and publish a price list for items in the Formulary.

Each regional board shall establish a program for the purchase and distribution of drugs and other medical supplies for use by the health facilities in its region. This program will provide for the purchase of each item by competitive bidding or based on the price listed by the National Health Board, and it will provide for the distribution of drugs under their generic names.

Sec. 433—Miscellaneous functions of the National Health Board. The National Board shall, at the end of each calendar year, publish a report describing the operations of the Service during the preceding fiscal year and surveying the future health needs of the Nation and plans the Board has to meet these needs.

The National Health Board shall publish and disseminate to area health boards, for use by users, a comprehensive dictionary of terms used in health care records and services.

TITLE V—FINANCING OF THE SERVICE

Health service taxes

Sec. 501—Individual and corporate income taxes. The Internal Revenue Code of 1954 is amended by adding a new part on health service taxes. These taxes are imposed on the taxable income of every individual, estate, trust, and corporation, increasing their tax liability in accordance with a table included in the Act. These taxes apply to taxable years including and after the effective date of health services.

Sec. 502—Other changes in the Internal Revenue Code of 1954. The Internal Revenue Code of 1954 is amended to delete any income exclusion for contributions to health plans providing health care and supplemental services that are provided under this Act; to deny deductions of payments for health care services provided

under this Act; to deny deductions for contributions to medical and hospital facilities; and to repeal Medicare taxes. These amendments apply to taxable years including and after the effective date of health services.

Sec. 503—Existing employer-employee health benefit plans. No contractual or other nonstatutory obligation of an employer to pay or provide health services to his employees or others shall apply after the effective date of health services, to the extent such services are provided under this Act.

Sec. 504—Workers compensation program. No worker's compensation program shall pay for or provide health services after the effective date of health services, to the extent such services are available under this act.

Health Service Trust Fund

Sec. 511—Establishment of Health Service Trust Fund. There is created on the books of the United States Treasury a trust fund to be known as the Health Service Trust Fund. Funds received from health services taxes shall be appropriated to the Trust Fund.

Sec. 512—Transfer of funds to the Health Service Trust Fund. On the effective date of health services, all of the assets and liabilities of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Insurance Trust Fund are transferred to the Health Service Trust Fund. In addition to the funds received from health service taxes, there is also appropriated to the Trust Fund a contribution from general revenues equal to 40 percent of the funds received from health service taxes.

Sec. 513—Administration of Health Service Trust Fund. The Trust Fund shall be administered by a Board of Trustees, composed of the Secretary of the Treasury, the Secretary of Health and Human Resources, and the chairperson of the National Health Board, according to the accepted standards for such federal trust funds. The Secretary of the Treasury shall pay from time to time from the Trust fund such amounts as the National Health Board certifies are necessary to provide health care and supplemental services under this Act.

Preparation of plans and budgets

Sec. 521—Determination of fund availability. The National Health Board shall, not later than January 1 of each year, initially fix the maximum amount of funds which may be obligated during the fiscal year beginning on October 1 of such year. Such amount may not exceed the lesser of 140 percent of the expected net receipts from health services taxes, or the amount spent during the previous year adjusted to reflect changes in the cost of living and scope and cost of services. The National Health Board may obligate less funds, if it determines that the cost of providing services has lessened, or additional funds if necessary because of an epidemic or other unexpected occurrence.

Sec. 522—Preparation of area plans and budgets. Each community board shall, by January 1 of each year, submit to its respective district board a plan and budget for the fiscal year beginning October 1. Each district board, in consultation with its community boards, shall, by February 1, submit to its respective regional board a plan and budget for the fiscal year beginning October 1. Each regional board, in consultation with its district boards, shall, by March 1, submit to the National Board, a plan and budget for the fiscal year beginning October 1. In preparing these budgets, each area health board shall specify its operating, prevention, capital, and research expenses for the coming fiscal year and for the five-year period beginning with that fiscal year.

Allocation and distribution of funds

Sec. 531—National budget. The National Health Board shall, as soon after April 1 as practical, transmit to the regional boards a national health budget for the fiscal year beginning October 1. It shall divide the total funds available into funds for ordinary operating, preventive health, capital, and research expenses, all divided into funds for use by the National Health Board and funds for the regions, and funds for special operating expenses as described in section 534. Funds for ordinary operating preventive health measures and research expenses are allocated to regions in proportion to their populations. During the first ten fiscal years, priority in capital funds shall be given to areas lacking adequate health care facilities. The budget shall be adopted upon approval by a majority of the regional boards.

Sec. 532—Regional budgets. Each regional board shall, as soon as practicable after adoption of the national health budget, transmit a regional budget to each district board in its region. This budget shall be adopted upon approval by a majority of the district boards. Funds for ordinary operating, prevention and research expenses shall be allocated to each district in proportion to population.

Sec. 533—District budgets. Each district board shall, as soon as practicable after adoption of the respective regional health budget, transmit a district budget to each community board in its district. This budget shall be adopted upon approval by a majority of the community boards. Funds for ordinary operating, prevention and research expenses shall be allocated to each community in proportion to population.

Sec. 534—Special operating expense fund. A fund for special operating expenses shall be incorporated into each budget prepared by the National Health Board. Special operating expenses include the costs of care and treatment of users 65 years of age and over, care and treatment of persons confined to full-time residential care institutions, special health needs of low-income individuals, special health needs of residents of rural areas, special health needs arising from environmental or occupational health problems, special needs from unexpected occurrences, and the conduct of environmental inspection and monitoring sevices.

The special operating expenses fund is allocated as follows: Funds for the additional expenses associated with senior citizens, and with persons confined to residential care institutions, are allocated to districts and communities and consist of basic capitation amounts multiplied, respectively, by the number of senior citizens and number of residents in such institutions, in the respective areas. The National Health Board shall determine the basic capitation amounts.

Funds for the needs of low-income residents are allocated to communities in proportion to the number of residents having incomes below the poverty level. (The total of these funds shall be no less than 2 percent of the ordinary operating expenses.) Funds for special environmental and occupational health needs are allocated by the National Board to regional boards in accordance with its determination of such needs. (The total of these funds shall be no greater than one-half percent of the ordinary operating expenses.) Funds for unexpected occurrences shall be retained by the National Board and allocated by them. (These funds shall be no greater than one-half percent of the ordinary operating expenses.) Funds for environmental inspection and monitoring services shall be allocated to the area health boards performing such services.

Sec. 535—Distribution of funds. Funds shall be distributed by the National Health Board from the Trust Fund. No health board may request or receive funds from any other source. Area health boards may retain funds received from the National Health Board for two years after receipt of funds; after this period, unexpended funds must be returned to the National Health Board for deposit in the Trust Fund.

Sec. 536—Annual statement, records, and audits. Each area health board shall prepare annually and transmit to the National Health Board a statement that accurately shows the financial operations of the board and its facilities. The National Health Board and the Comptroller General of the United States shall, for auditing purposes, have access to all records and documents of the Service.

General provisions

Sec. 541—Issuance of obligations. The National Health Board is authorized to borrow money and to issue and sell such obligations as it determines are necessary to carry out this Act, but only in such amounts as are specified in appropriation Acts. The aggregate amounts of obligations at one time shall not exceed $10 billion. The National Health Board may pledge the assets of the Trust Fund and pledge and use its revenues to pay principal and interest on obligations. The service shall abide by the general rules and procedures for the issuance of obligations followed by agencies of the Federal Government. Obligations issued by the Service shall be obligations of the United States Government and payment is fully guaranteed by the Government.

TITLE VI—MISCELLANEOUS PROVISIONS

Sec. 601—Effective date of health services. The effective date of health services under this Act is January 1 of the fourth calendar year after the year in which this Act is enacted.

Sec. 602—Repeal of provisions. Effective on the date of health services, portions of the Public Health Service Act, the Social Security Act, and other acts relating to the provision of health care services and the conduct of health and health care research are repealed. Portions of the Public Health Service Act relating to health worker education remain in effect until four years after the effective date of health services.

Not later than 3 years after the date of enactment of this Act, the president shall prepare, in consultation with the National Health Board, and transmit to Congress legislation to repeal or amend additional provisions of law that are inconsistent with the purposes of this Act. Such legislation shall include transfer of such author-

ity of the Secretary of Health, and Human Resources relating to standard-setting, regulation, and licensing, as the President determinations, after consultation with the National Health Board to be appropriate.

Not later than one year after the effective date of health services, the National Health Board shall report to the President and to the Congress on how the Service is carrying out the purposes of the program which have been repealed.

STATEMENT OF FREDERICK A. MEISTER, JR., PRESIDENT, DISTILLED SPIRITS COUNCIL OF THE UNITED STATES, INC.

My name is Fred Meister. I am President of the Distilled Spirits Council of the United States which represents the producers and marketers of approximately 90% of the distilled spirits sold in the United States. Today I am also testifying on behalf of the Wine and Spirits Wholesalers of America, the National Licensed Beverage Association, the National Liquor Stores Association, the American Beverage Alcohol Association and the National Association of Beverage Importers. Together, these organizations represent well over 30,000 businesses involved in the production, importation, distribution and retail sale of beer, wine and liquor. They and hundreds of thousands of workers in these businesses are vitally concerned about issues under discussion here today. I am grateful today to also have the support in opposition to federal excise tax increases of the Chamber of Commerce of the U.S., the National Association of Manufacturers, the American Business Conference, the National Governors' Association, the National Conference of State Liquor Administrators and the AFL-CIO. I appreciate the opportunity to present to you some facts on an issue of importance to all Americans.

The Advisory Council on Social Security has been asked to study and make recommendations on how to prevent the collapse of the medicare system Saving this vital health service program will clearly require major surgery. On July 16, the Washington Post discussed "the runaway medical inflation problem" which now accounts for over 10% of the GNP. Unfortunately, there are those who see your work as an opportunity to advance other private agendas at the expense of your time and the public welfare. I refer specifically to proposals that drastically increased taxes on beer, wine and liquor be incorporated into the package of funding proposals you must devise. Since some of those who will appear here today have already proposed the same tax increase to other groups to be used for other purposes, it is clear that they really have a tax increase looking for a reason. I urge you to carefully scrutinize the arguments put forth by those who are more interested in using the tax code to impose their radical beliefs than they are in helping solve the medicare crisis.

Alcohol beverage taxes should neither be increased nor diverted from general revenues for medicare or any other special purpose. The Federal government has wisely avoided increasing their taxes on alcohol for a number of years. These taxes are regressive and no benefits can be shown to justify punishing 100 million light and moderate drinkers for their personal consumption choices. Furthermore, the states have aggressively raised their alcohol taxes during this period, some 121% in the case of distilled spirits. Those who claim that liquor taxes have not been increased in thirty years are keeping two sets of books. As far as the consumer is concerned, the rapidly rising state taxes have and left the tax burden on the average bottle of liquor at 44%—far higher than the tax on any other product.

States now depend on alcohol taxes for an average four percent of their revenues—any major Federal increase would both cost them greatly and immediately in lost current revenues as well as long term in reduced capacity of the products to take any further state tax increases.

In 1983 alone, 13 states have already taken substantial increases in their liquor taxes. The percentages are dramatic. Alaska—40% increase; New York—25% increase; New Mexico—142% increase; Connecticut—20% increase; Florida—36.8% increase. Anyone who says liquor taxes haven't been increased in 30 years is playing fast and loose with the facts.

Proponents of major alcohol tax increases not only keep two sets of books insofar as recognizing the history of these taxes is concerned, they keep two sets of books with respect to the effects of a major increase. On one hand, they say revenues will be increased in direct proportion to the tax rate increase. On the other hand they boast that consumption will fall and with it, problems associated with alcohol abuse. Clearly, government must decide if they want to make a lot of money from the sale of alcohol or if they want people to stop drinking. Both goals cannot simultaneously be achieved.

There is a persistent myth that people will always drink and so the tax rate doesn't matter. Perhaps alcoholics will always drink, but fortunately, they are a small minority of consumers. Those of us who can take it or leave it will leave it if government forces the price too high. A 100% increase in the tax on spirits would cause a jump in the retail price, overnight, of an average 40%–50%. About $3.25 per liter. Conservative estimates are that sales would drop at least 20%. Thousands of small retailers would face bankruptcy. A package store with $30,000 in inventory would have to immediately come up with $12,000 to pay the new tax on merchandise already on hand. Many would be unable to do this. Meanwhile, the thirst of many could be quenched by the output of over 10,000 small stills licensed by the federal government in recent years for gasohol production. No adequate police force exists to assure that the output from these stills is used for fuel. The high tax will give the modern day moonshiner a tremendous price edge on the legal producer.

I assure you, we are not painting an overly gloomy picture. The distilled spirits industry is already in distress. Per-adult consumption of liquor is lower today than at any time since 1967. Total volume declined more than 2.5% last year. A recent survey of some of our members who represent 58% of the domestic liquor production showed that employment dropped 5.5% in 1982. Capacity utilization is down to only 64.6%. In 1982 and 1983 these members closed the doors on eight factories putting over 1,400 people out of work. this is without a tax increase. The effects of a major tax increase would be catastrophic.

We can learn from the recent experience in other nations. Tax increases in Australia in 1978 forced prices up about 40%. Sales immediately dropped 26%. In 1977, Denmark increased tax rates 37.5%. Sales dropped so much that total revenue declined 12%. By 1981, they were still collecting less than before the tax increase. In Germany, 30% higher taxes resulted in 20% less sales. The examples go on and on. Consistent with the view that it is moderate drinkers who reduce consumption under such conditions, we have no evidence that alcohol abuse declined in these nations.

It has been argued that since alcohol-related health costs run into billions of dollars per year, it is equitable to tax alcohol and give these revenues to medicare. Another case of two sets of books. This argument only makes sense if medicare is actually paying those billions of dollars and if there is no offsetting reduction of health costs which can be related to alcohol. Actually, the Office of Technology Assessment, in a report issued earlier this year, put the alcohol-related costs of medicare at $150 million. And while no one has been able to put a dollar value on it, the legendary Framingham, Massachusetts, study of heart disease and others have found that moderate drinkers had as much as a 30% lower risk of heart attacks than did nondrinkers. Cardiovascular disease, may I remind you, is the number one killer in America and a leading drain on medicare funds. Does it make sense to discourage moderate drinkers—some 100 million of them—in a misguided attempt to make the 5–10 million problem drinkers pay more for their illness?

Clearly, as long as medicare costs are escalating, it makes no sense to look to the declining revenues from alcohol as a base on which to assure medicare's future.

Americans are a moderate drinking people. We rank 18th among industrialized nations in per capita alcohol consumption. The average adult drinks about two drinks per day—a level found to be beneficial in almost every study. Alcohol abuse remains a serious problem—but it is not typical of drinking in America. The beneficial customs of 100 million social drinkers should not be lumped with the problems of alcoholics and collectively labeled undersirable. Nor should 100 million social drinkers be asked to pay an extraordinary share of medicare or other programs when they do not collect a disproportionate share of the benefits.

The alcohol beverage industry is united in support of sound education, research, treatment and other programs to reduce alcohol abuse problems. Documents submitted with this testimony describe many of these efforts conducted by DISCUS and the industry-wide Licensed Beverage Information Council. We've learned that alcoholism is a medical problem not an economic one. It is not caused by the tax code and cannot be cured by it.

The future of medicare is too important to rest on the unreliable base of alcohol taxes or be caught up in an unrelated debate on the merits of drinking or in financing gimmicks put forth by those with private objectives. We seek to read everyday of abuse or health problems associated with misuse of a vast array of products from salt to sugar. There is no justification for singling out alcohol any more than has already been done for extreme taxes which punish all users, not just those whose drinking results in problems.

I urge you to reject the ill-founded proposals for increasing alcohol taxes and seek responsible financial solutions for the medicare system. I respectfully request your

attention to the additional supporting documentation I am submitting with this testimony, especially to the following:

First, a resolution adopted by the National Conference of State Liquor Administrators opposing an increase in the federal excise tax.

Second, a letter from the National Governors' Association opposing the tax hike.

Third, a letter from the AFL–CIO opposing the tax increase.

Finally, a copy of President Reagan's New Federalism plan in which he proposes elimination of federal excise taxes on beverage alcohol by the end of the decade.

Thank you for the opportunity to speak with you today. I'll be happy to answer any questions you may have.

DISTILLED SPIRITS COUNCIL OF THE UNITED STATES, INC.

MEDICARE REVENUES SHOULD NOT BE RAISED THROUGH ALCOHOL EXCISE TAXES

1. Earmarking alcohol taxes for Medicare does not address the real, long-term problems underlining impending Medicare deficits.

It has been well documented that the primary causes of spiraling Medicare costs are 1) an aging population, 2) technological advances that permit costly application of life-extending medical support systems, and 3) inflation in health-care costs at all levels. These are serious problems which need to be addressed in a comprehensive manner. Cosmetic devices such as earmarked alcohol taxes do not address the underlying problems and may divert attention from more meaningful, comprehensive solutions. The Congressional Budget Office has stated, "The HI Trust Fund deficit is so large that treating the underlying problems of rapidly rising medical-care costs will probably have to be an important part of any long-run solution to Medicare's financing problems."

The Advisory Council on Social Security itself recognizes that any realistic solution to future Medicare deficits must be a long-term solution. The Council has stated that "Any recommendations for eliminating [the Medicare] deficit should include long-term revisions that ensure that savings or increased revenues continue in the out-years . . . the financing problems of the Hospital Insurance trust fund are essentially permanent, thus requiring long-term solutions . . . the Council will seek long-term reforms which assure the continued viability of the program . . ."

2. Alcohol taxes will not provide significant revenues toward Medicare deficits.

Outlays for the HI Trust Fund are projected to be $175 billion in 1995 (compared to $35.6 billion in 1982). In total, HI Trust Fund outlays could be as high as $1.6 trillion from 1983 through 1995. At least $200–$300 billion in additional income or decreased outlays will be required to keep the trust fund solvent through 1995.

Alcohol taxes will contribute an insignificant and declining portion of impending deficits. It has been estimated, by industry and independent analysts, that doubling the FET on distilled spirits might raise, at best, an additional $1–$1.5 billion a year. Revenues of this magnitude contribute virtually nothing toward Medicare deficits.

Estimates by the Office of Management and Budget (OMB) and Treasury regarding revenue increases from a 25% or 50% increase in the FET may overestimate the revenue gain from a spirits tax increase by roughly 100 percent. OMB/Treasury estimates that a 50% increase will raise gross revenues by about $1.7–$1.8 billion each year (net revenues by 75 percent of this or $1.3 billion each year). In fact, if the FET on spirits is raised 50%, prices will rise about 20 percent on average and, using OMB's estimated price elasticity for spirits of −.79, volume could be reduced by about 15 percent. Gross FET revenues will rise by at best $1 billion, net revenues by $750 million, roughly half of OMB/Treasury estimates.

Over the long-term, distilled spirits are a slow-growth revenue source. Per capital consumption of spirits has been steady for many years. In 1982, spirits apparent consumption dropped 2.5%; FET revenues dropped 6 percent. The opinion of industry analysts is that spirits consumption may grow only modestly in the next decade. Thus, alcohol taxes will provide an inconsequential and increasingly smaller share of Medicare's long-term needs.

3. There is no demonstrable health hazard from moderate alcohol consumption and it is inequitable to tax the majority of drinkers for health costs incurred by a small minority.

The majority of alcohol consumers do not abuse alcohol. Taxing alcohol for Medicare forces light and moderate drinkers to pay for health problems they do not experience or cause.

Moderate alcohol consumption not only is not harmful, but recent research indicates it may be beneficial to health. Studies have indicated an association between

moderate alcohol intake and reduced risk of cardiovascular disease [1] (a leading cause of death) compared to abstinence from alcohol.[2] One large-scale study, adjusted, adjusted for smoking, sex, race, and age, found that the mean hospitalization rate for coronary heart disease was lowest among those drinkers having two or fewer drinks/day; higher among abstainers. The study also found that those having 3–5 drinks per day had a lower mean hospitalization rate than non-drinkers. The study concludes that "there is almost no evidence that up to 30 ml. of ethyl alcohol daily carries any significant cardiovascular risk . . . two standard drinks/day are apparently safe."

A 1977 report, the National Health Interview Survey [3] reports that 42 percent of the population drink occasionally, 15.5 percent drink 1 or 2 times a week with only 14 percent reporting drinking 3 or more times a week. Clearly, the bulk of the drinking population does not appear to consume alcohol in a way which imposes health costs on the nation.

4. The illness of alcoholism should not be singled out for a special health tax.

Alcoholism is a recognized illness, not a "bad habit." Those affected by it are no more responsible for the illness than those affected by cancer or any other disease. Taxing all consumers of beverage alcohol will not do anything about the illness experienced by a small proportion of drinkers. There is not precedent for singling out victims of any illness for a special tax.

There are no studies which quantify, with any degree of accuracy acceptable for policy purposes, the amount of Medicare benefits which go to beneficiaries with alcohol-related illness. While alcohol abuse is a serious health problem, whether or not its medical consequences impose disproportionate costs on the Medicare system is not known. Indeed, the few existing estimates of the overall health costs of alcohol abuse are inadequate and inappropriate because sound data are lacking.

The serious problem of alcohol abuse should not be minimized, but any objective examination of the issues must place alcohol abuse-related health consequences in perspective relative to all diseases and conditions. There is no basis for any assertion that alcohol abuse-related health conditions account for a disproportionate share of Medicare outlays.

There is available data (source: Health Care Financing Administration, unpublished) on Medicare outlays for Medicare reimbursements for short-stay hospital services in 1979. Short-stay hospital service reimbursements accounted for 57 percent of total 1979 Medicare outlays. The data indicate that diseases of the circulatory system and cancer account for 40 percent of these Medicare reimbursements. This is consistent with mortality rate data. Total 1979 Medicare outlays for a residual diagnostic category subsumed under "Diseases of the Digestive System" which includes liver cirrhosis, account for only 7 percent of Medicare outlays and liver cirrhosis necessarily accounts for a smaller percentage that this. (Table 1.)

The Office of Technology Assessment recently published a study [4] of the cost-effectiveness of alcoholism treatment approaches. In this study, they cite a figure of $150 million as the 1982 cost to Medicare of alcohol abuse. However, no derivation or breakdown of this estimate is provided. It validity is unknown.

The one study often utilized to back assertions about the cost of alcohol abuse [5] has been criticized on methodological grounds. This study estimated that the direct health care costs of alcohol abuse, in 1976 dollars, were $12 billion. One critique [6] of this estimate states that the authors "are liberal in measurement of the costs of alcohol abuse . . . by consistently interpreting unfortunate effects, such as work days lost and higher health care costs, associated with alcohol abuse as being caused by alcohol abuse . . . In developing estimates of health care costs, there is no attempt to go beyond the cruder comparison of use of health sources by alcoholic and non-

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[1] Wallace, et. al., "Alcohol and Hypertension: Epidemiological and Experimental Considerations," Lipids Research Clinics Program, Symposium on Alcohol and Cardiovascular Diseases, 1981. This study reviews 7 different research studies and alcohol and cardiovascular disease.

[2] Klatsky, et. al., "Alcohol Use and Cardiovascular Disease: The Kaiser-Permanente Experience," Symposium on Alcohol and Cardiovascular Diseases, 1981.

[3] U.S. National Center for Health Statistics, Advance Data from Vital and Health Statistics, No. 64, 1980.

[4] Office of Technology Assessment, "The Effectiveness and Costs of Alcoholism Treatment," March, 1983.

[5] Berry and Boland, "The Economic Cost of Alcohol Abuse," The Free Press, 1977. This study was utilized in Luce and Schweitzer, 1978, who did not themselves develop any new estimates. It is the basis for most estimates of alcohol abuse costs which usually just adjust the results for inflation.

[6] McGuire, "Measuring the Costs of Alcohol Abuse" in Josephson, et. al., "An Assessment of Statistics on Alcohol-Related Problems," 1980.

alcoholic populations . . . the major problem . . . is the disregard of other factors, such as mental illness and disorder, which are positively associated with alcohol abuse and may also be the cause of extra health costs."

5. Higher alcohol taxes will not reduce the incidence of alcohol-related health problems.

While it is true that higher spirits taxes will reduce total consumption of spirits, the key question is whether alcohol abuse will be reduced by a tax increase.

Dr. Philip Cook, an economist from Duke University, testified recently before the Advisory Council that, according to his research, changes in state liquor tax rates were statistically correlated with changes in cirrhosis rates. On the basis of this study, Dr. Cook made the categorical assertion that doubling the federal liquor tax would reduce the nation's cirrhosis mortality rate by 20 percent.[7]

This assertion is based on a "theory" of alcoholism which has no grounding in the extensive medical research on alcoholism or its treatment. The fundamental flaw in this theory is this failure to cite or examine relevant medical research, mass communications research, alcoholism treatment research, human development research, or alcohol education research.

This economic theory of alcoholism rests principally on the assumption that chronic, cirrhotic drinkers will cease or reduce drinking in response to price increases and correlations between cirrhosis rates and state tax rates reflect this phenomenon. As the author explains his logic: ". . . the cirrhotic process is interruptible—if at any time an alcoholic should stop drinking, his liver will cease to deteriorate. If his rate of consumption slows, then the deterioration process also slows . . . at any point in time, there is a 'reservoir' of people who are within one year of death from cirrhosis at their current rate of consumption. If some of them reduce their consumption in response to a tax increase, then not all of them will die in that year—i.e., the mortality rate will decline in the first year . . ."

This simplistic hypothesis about alcoholism totally belies the extensive research documenting the extreme difficulty of even intensive efforts to intervene with the drinking of chronic alcoholics. This is well known in the alcoholism treatment field and demonstrated in a substantial body of literature. A major work by Mendelson and Mello, "Diagnosis and Treatment of Alcoholism," examines this issue in detail.[8] Dr. Henry Rosett, M.D., in several research papers has documented the difficulties of intervention with alcoholic pregnant women, when the motivation to reduce their drinking is clear and compelling. As the Office of Technology Assessment concluded "the present review of the etiology of alcoholism and the effects of alcoholism on various subgroups illustrates the complexity of alcoholism as a social and health-care problem." The author does not cite any of the major research experts on the treatment of alcoholism to support his theory of alcoholism.

Further, the question of whether or not the cessation of drinking by a chronic cirrhotic drinker will interrupt the disease of cirrhosis is a complex medical issue. The author does not cite the opinions of medical experts in support of his assumption that cessation of drinking in the late stages of cirrhosis arrests either the disease or its attendant complications for an appreciable period of time.

This type of research further errs in assuming that cirrhosis rates are a reliable proxy variable for chronic/heavy drinking. A multinational study by Dr. David Pittman[9] examines in detail the weaknesses in using cirrhosis rates as a proxy for chronic/heavy drinking. First, clinically only a small minority of alcoholics and heavy drinkers develop liver cirrhosis; and some abstainers and moderate drinkers are victims of liver cirrhosis disease. Second, a number of factors are involved in the development of liver diseases such as cirrhosis, including nutritional factors, pollution, exposure to drugs and chemicals, and genetic factors, Furthermore, liver cirrhosis mortality is not randomly distributed in either the entire or drinking population. There are major differences by sex, age, racial, and ethnic status. Cirrhosis rates are correlated strongly with the race-ethnic proportion of the population. Non-white males have a much higher incidence of cirrhosis mortality than most other groups. Non-white females have a higher incidence than white females. Statistically, therefore, observed changes in liver cirrhosis rates can be due to a host of factors unrelated to alcohol consumption. As the Pittman study notes, "Burton Combs, Chairman of the American Liver Foundation and a professor at the Universtiy of

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[7] Cook, "Alcohol Taxation: Prevention, Distribution and Revenue Effects," prepared for the National Academy of Sciences Conference on Prevention of Alcohol Abuse, May, 1983.

[8] Mendelson and Mello, "Diagnosis and Treatment of Alcoholism," McGraw Hill, New York, 1979, 405 pages.

[9] Pittman. "Primary Prevention of Alcohol Abuse and Alcoholism: An Evaluation of the Control of Consumption Policy," Social Science Institute, Washington University, 1980.

Texas Health Science Center in Dallas, has warned against equating liver cirrhosis with alcoholism. This liver researcher estimates that approximately one-half of those with cirrhosis do not have a problem with alcohol. . . The range of percentage of deaths from liver cirrhosis related to alcohol ingestion is so imprecise that it is not even meaningful for constructing social policy."

Moreover, a seminal study by Whitlock[10] found that non-alcoholic cirrhosis deaths correlate positively and highly significantly with measures of alcohol intake, raising a serious question about the utility of cirrhosis death rates as a proxy for heavy drinking.

Given the lack of grounding of the theory's basic premises in existing medical and alcoholism treatment research, the imprecision of the link between cirrhosis mortality rate data and alcoholism, and the number of factors which can affect significantly the year-to-year variation in cirrhosis mortality rates, the categorical conclusion that doubling the FET on liquor will reduce cirrhosis mortality by 20 percent goes well beyond the limitations of this kind of research and contradicts the findings of experts in the alcoholism treatment field. A recent research paper by Mulford and Fitzgerald,[11] which examined overall alcohol consumption and several indicators of problem drinking in Iowa, between 1961 and 1979, concluded that there was an overall increase in total consumption but little change in problem drinking. They conclude that "the nature and magnitude of the alcohol problem is influenced by too many forces interacting in too complex a manner to be understood or solved by merely identifying and correcting a biological abnormality or by formal efforts to control the total volume of alcohol consumed by the population . . ." There is no empirically-grounded basis for the assertion that heavy/chronic drinking is responsive to economic variables such as prices. Alcoholism is not a rationale economic decision; it is a complex, treatable illness.

6. Raising the FET will jeopardize an important state revenue source.

States rely heavily on beverage alcohol taxes. Between 1955 and 1980, while Federal revenues from spirits doubled, state and local revenues nearly quintupled. State and local revenue per gallon rose by 121 percent between 1951 and 1980.

Beverage alcohol revenues are more critical to the state than to the Federal government—accounting on average for 4 percent of state tax revenues and in some states much higher (11 percent in New Hampshire). Beverage alcohol revenues are equivalent to about one-third of state Medicaid costs. States are in severe budget difficulties and are looking to beverage alcohol taxes. In the first three years of the Eighties, there were 31 tax increases on spirits and/or mixed drinks, twice the rate of tax increases of the Seventies. Thus far in 1983, 94 spirits tax bills in 38 states have been proposed and to date seven tax/markup increases have occurred. State revenues from spirits already are threatened by declining sales. In 1982, spirits consumption dropped in 41 states and D.C.

An FET increase will lead to lost revenues in many states and eliminate alcohol taxes as a stable source of future income. Governor Snelling of Vermont, on behalf of the National Governors' Association, stated last year that "these taxes have long been regarded as state revenue sources and should remain so."

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9. Earmarking is poor fiscal policy.

Earmarking promotes inefficiency in the administration of the Federal budget. Earmarked taxes "tie up" a revenue source and impede the allocation of funds from general revenues toward their best use. Furthermore, with regard to Medicare, it breaks the link between payment of payroll taxes and eligibility for Medicare (Part A) benefits.

STATEMENT OF JAY HARVEY, LEGISLATIVE DIRECTOR, FOOD & ALLIED SERVICE TRADE DEPARTMENT, AFL–CIO

Chairman Jacobs and Members of the Committee, my name is Jay Harvey, and I am Legislative Director of the Food and Allied Service Trade (FAST) of the AFL–CIO. We represent fifteen international unions with 3.5 million members in a wide variety of service industries. Many of their jobs are directly dependent on the sale of consumer products, jobs which historically have been very sensitive to consumption

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[10] Whitlock, "Liver Cirrhosis, Alcoholism and Alcohol Consumption," Quarterly Journal of Alcohol Studies, 1974.

[11] Mulford and Fitzgerald, "Changes in Alcohol Sales and Drinking Problems in Iowa, 1961–1979," Journal of Studies on Alcohol, vol. 44, No. 1, 1983.

based taxes, such as sales or excise taxes. These members are also the consumers whom these regressive taxes hurt the most.

I am here today in support of the Heaps-Arnold Report, the dissenting opinion of the Social Security Advisory Council. More specifically, I am here to voice FAST's strong opposition to the use of increased alcohol and tobacco excise taxes to help fund Medicare.

There are two fundamental and compelling reasons to oppose the earmarking of increased excise taxes to produce increased revenue for Medicare. First, excise taxes are regressive, disproportionately burdening those with lower incomes. Second, excise taxes are not a stable revenue source.

Excise taxes are regressive—the percent of income eaten by these levies dramatically increases as income decreases. An increase in federal excise tax rates will make even heavier an already significant tax burden on these with lower incomes. It would be altogether unfair to fund Medicare at the expense of these individuals.

An equally convincing reason to oppose the earmarking of increased excises for Medicare is that excise do not provide stable revenues.

Alcohol and tobacco are two of the most highly taxed commodities in the United States. They appear to be reaching the limit in the amount of revenue they can produce.

Indeed, time and time again, U.S. states have substantially increased excise taxes on alcohol and tobacco, anticipating a wealth of new revenue. And what, often, is the result? Decreased sales of the products and revenues which fall far short of initial projections.

With an increase in the federal excise tax on alcohol and tobacco, revenues would be likely to remain flat or would increase only slightly. If the taxes were increased greatly, revenues might even drop. Either way, an excise tax increase is obviously not a prudent way to fund one of our nation's most relied-on programs.

The Medicare program, with beneficiaries numbering close to 30 million, does not deserve such shaky and unreliable funding as would be provided through increased excise taxes on alcohol and tobacco. In addition, it should not be funded by the nation's lower-income citizens, who would have to pay a much greater share of their incomes toward increased excises than those with higher incomes. Therefore, on behalf of FAST, I strongly urge you to reject any proposal to earmark increased tobacco and alcohol excise taxes to fund Medicare.

STATEMENT OF DICK WARDEN, LEGISLATIVE DIRECTOR, INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE & AGRICULTURAL IMPLEMENT WORKERS OF AMERICA (UAW)

Mr. Chairman, my name is Dick Warden. I am the Legislative Director for the UAW. The UAW appreciates the opportunity to set forth its views concerning the Medicare financing crisis and the various proposals which have been advanced for solving that crisis. The UAW commends the Committee for holding hearings on this important subject, and hopes that this will serve as the basis for prompt, constructive action by the Congress next year.

One thing that nearly everybody can agree on is that the Medicare system is rapidly approaching a financial crisis that threatens its continued existence. Informed estimates suggest that Medicare's Part A Hospital Insurance Trust Fund will be depleted by 1990 or thereabouts. These estimates are based on the simple observation that the trust fund's liabilities are increasing at a much faster rate than its revenues.

This problem stems from the fact that revenues from Social Security payroll taxes have been increasing less rapidly than hospital costs. Over the next decade, while Social Security payroll taxes are projected to increase at a 7% annual rate, hospital costs are expected to show a 13.2% annual increase.

Since the inception of the Medicare program costs have increased dramatically . . . from $4.7 billion the first year to about $55 billion in fiscal year 1983. The Hospital Insurance program has accounted for two-thirds of this over 1,000 percent increase in Medicare costs.

It is easy to lose oneself in a search for the causes of this problem, but no rationalization can explain away the fact that inflation in hospital and physicians' costs have for years outpaced inflation in other sectors of the economy. These costs represent the bulk of Medicare outlays. The Hospital Insurance program has experienced average annual increases in costs that have been seven times greater than enrollment increases and six times greater than utilization. Medicare Part B, the Supplementary Medical Insurance program, has seen costs rise six times faster than enrollment and two-and-a-half times faster than utilization.

The UAW does not believe that the answer is to simply keep throwing money at this problem. But that is precisely the solution proposed by the President's Advisory Council on Social Security. The Advisory Council issued a set of recommendations that, at best, will simply defer the crisis by adding money to the Medicare funds and shifting costs to beneficiaries and the private sector without doing anything to control the rising costs of the health care system. This is not surprising. The Advisory Council included only two labor representatives, no representative of the elderly or the disabled, and was overwhelmingly composed of providers, insurers, and business representatives.

The Advisory Council's recommendations—raising the age of eligibility for Medicare, increasing hospital co-pays, raising Part B premiums, and taxing employer-provided health insurance—are the wrong solutions and will not work because they merely treat the symptoms, not the root cause of the problem.

These purported solutions, as well as other proposals for further reductions in benefits, higher deductibles and co-pays, means-testing, and a voucher system, are firmly rooted in the notion that Medicare's problems stem from people having too much health insurance. The premise is that the elderly over-use their health care benefits because they are not "cost-conscious." The obvious solution, from this point of view, is to discourage perceived over-use by shifting costs to beneficiaries in the hope that they will become more cost-conscious and selective when seeking health care services.

The UAW rejects the idea that higher deductibles and co-pays, or dumping more of the burden on private sector employers, will solve Medicare's problems by making beneficiaries "cost-conscious," thereby reducing unnecessary utilization. Such thinking ignores Medicare's already burdensome deductibles and co-pays, and is based on mistaken notions about the nature of the health care system. Medicare beneficiaries do not make most medical decisions; providers do. Medical care is not governed by classical notions of free market economic forces. The suppliers (providers of health care services) make the major and most expensive decisions in the health care market. They decide who goes to the hospital, what tests are needed, what procedures are appropriate, and what drugs should be taken.

The UAW has steadfastly resisted the arguments advanced by many employers at the collective bargaining table that we ought to impose higher co-pays and deductibles and other cost-shifting arrangments on workers. We have not simply been trying to save out-of-pocket money for our members, although that is important. The point is that we know that the rampant inflation in the health care industry cannot be solved by punishing patients financially. The system of health care delivery must be addressed as a whole. We know we can help control inflation in health care costs by participating with management in joint, cost-saving, quality assurance committees that deal with the problem of health care inflation through approaches that enhance quality and focus on the health care delivery system.

In and out of these committees, the UAW has played a pivotal role in the development and promotion of alternatives health care delivery systems such as health maintenance organizations and dental capitation programs. Such alternatives have the capacity to hold costs down while actually improving the quality and scope of benefits. They represent true reform of the delivery system by placing providers of care at risk for the economic consequences of their decisions.

In addition, joint UAW-employer committees have developed and launched efforts designed to reduce unnecessary utilization, including programs for mandatory second surgical opinions, ambulatory surgery, and prior authorization for specified procedures. These programs have the added virture of sparing our members exposure to unnecessary medical risks, while saving money.

These approaches work because they are directed at the real problem—our inefficient health care delivery system. Medicare financing concerns must be addressed in this same manner. It is not enough for labor or Medicare beneficiaries to stick a finger in the dike—by passively acquiescing to more cost shifiting—when water is cascading over the top.

Comprehensive legislative solutions—directed at reforming the health care delivery system, rather then simply imposing more costs on the taxpayers or the users of the system—are ultimately necessary. The proposed "Medicare Solvency & Health Care Financing Reform Act of 1984" introduced by Representative Gephardt (H.R. 4870) and Senator Kennedy (S. 2424) embodies this type of approach. In our judgment, this legislation represents a contructive response to the challenge of controlling escalating health care costs and solving the financing problems facing the Medicare program.

This legislation would eliminate the deficit currently projected for the Medicare program, without raising taxes or cutting benefits. It would restore solvency to the

program by addressing the root cause of the financing problems—namely, the rampant inflation in the health care industry.

The legislation recognizes that the only truly effective way to contain health care costs is to mount a comprehensive effort which encompasses private as well as publicly financed health programs. Otherwise, any effort to hold down costs will simply lead to "cost-shifting" from public to private payors. At the same time, the legislation accords great flexibility to the states in designing the type of comprehensive cost control program which is best suited to their particular needs. In addition, the legislation would make a number of specific reforms in the Medicare program, including disincentives for excessive hospital admissions and the inclusion of inpatient physician services and capital costs under the existing prospective payment system.

In addition to prompt action to check rising health care costs, the UAW strongly believes that any legislation should also address the other major problem confronting the Medicare program—that is, the inadequate health care protection currently afforded to our nation's senior citizens. A significant proportion of the elderly have trouble obtaining needed care and the entire Medicare population is feeling the "access" pinch. In fact, the elderly will soon be spending more of their per capita income on health care than they did before the inception of the Medicare program. While direct out-of-packet payments for personal health expenditures declined from 53% to 28% of total health expenditures for the elderly between 1966 and 1981, aggregate spending has risen so sharply that the per capita financial liability for the elderly actually increased from $237 (average 1966 out-of-pocket expense) to $885 (average 1981 out-of-pocket expense).

In 1966, these direct expenditures represented 15% of the mean income for the elderly. By 1981, however, these direct expenditures still accounted for 13% of the elderly's mean income, and they are expected to reach 16% of the elderly's mean income by 1985—an even heavier burden than was the case in 1966.

Thus, we have a program that is failing to live up to its goal of providing our elderly with the best health care that medical science can offer, so that despite declining vigor and increased vulnerability to chronic conditions, their lives can be as fulfilling as possible. At the same time, we are faced with the Trustees' Report which states that if nothing is done to reduce the costs of the Medicare system, funding will have to be increased by 48% of spending will have to be cut by 32% in order to maintain the solvency of the program.

The United States has the most technologically advanced—and the most expensive—health care system in the world. Yet, for all of our sophisticated technology and the world's largest supply of doctors, we have not solved our problem of inequitable access to the health care system. The doors of too many medical providers remain closed to millions of Americans, including millions of the elderly, who lack adequate insurance.

In the long run, the only real solution is a comprehensive national health insurance system. The health care system needs to be directed away from the profit motive and steered toward meeting human, not corporate, needs. We need to focus attention on lower cost, preventative care and appropriate long-term care for chronic conditions, not high technology, high cost intervention for those lucky enough to have adequate coverage, after they are sick. Only then will we come close to making the right to needed health care a reality of all Americans, including the elderly and disabled.

Thank you.

STATEMENT OF THE JOINT PUBLIC AFFAIRS COMMITTEE FOR OLDER ADULTS (JPAC)

We submit this testimony on behalf of the thousands of elderly who are affiliated with the Joint Public Affairs Committee for Older Adults (JPAC). JPAC is a citizen action coalition of older adult representatives of more than 100 senior centers throughout metropolitan New York. Through our network of social action committees, JPAC educates older persons to advocate on their own behalf on legislative and community issues and, thereby, improve services and programs designed for them. JPAC is sponsored by JASA—the Jewish Association For Services For the Aged, and other senior organizations in metropolitan New York.

As advocates dedicated to improving the quality of life for all Americans, the provision of affordable, quality health care, especially Medicare, has been a primary concern.

We, therefore, appreciate this opportunity to present our views to the Subcommittee on Health of the House Committee on Ways & Means. We do hope you will support our efforts to assure solvency in the Medicare program through enactment of

systemwide cost-containment policies. We hope we will be given opportunities in the future to make additional comments and recommendations as new proposals are put forth.

As you know, in efforts to find solutions to the projected financing problems of Medicare, various "cost-saving" proposals have been advanced. The majority of these recommendations would shift the burden of the costs to the older beneficiary. Alternative strategies which would resolve the inflationary costs of the Medicare program are available and must be pursued so that elderly beneficiaries will not continue to be victimized because they are old and sick; they simply cannot afford it.

The current crisis in Medicare is largely due to runaway medical inflation, which not only jeopardizes the future of Medicare, but threatens the future of our entire health care system. In our view, solutions to the Medicare crisis lie in restructuring the total health delivery system by containing rising medical costs. Simple cost-shifting proposals within Medicare will not maintain the program over the long run, and will place access to health care out of the reach of most older Americans.

Today, the average Medicare beneficiary pays as high a proportion of their income for health care as before Medicare was enacted. Medicare covers only 40–44% of an older person's total health bills. It does not cover costs of many vital services such as: prescription drugs, eye and foot care, dental care, and preventive check-ups. It provides only limited home care and other long term care. The provision of these preventive services would cut health care costs in the long run and in many cases, delay costly institutionalization.

The time for Health Care reform has come. JPAC will work to effect systemwide reforms and expansion of the Medicare program to meet the true needs of today's elderly. We will work toward the development of a national comprehensive health plan for all Americans. JPAC will work to defeat any and all proposals which would continue to erode health care coverage of older Americans by cutting benefits or increasing costs to beneficiaries. We ask you to join us in these efforts.

Specifically, JPAC members oppose the following (many of which were recommended by the Advisory Council on Social Security, the President, and the Senate):

Raising the age of Medicare eligibility.

Increasing and indexing Medicare deductibles and co-payments.

Replacing current hospital coverage with "Catastrophic Coverage"—requiring Medicare beneficiaries to pay higher costs for short-term hospital stays in order to finance long-term coverage.

This proposal would financially devastate the majority (97%) of Medicare beneficiaries who are hospitalized for short periods of time. Of the 7 million Medicare beneficiaries hospitalized each year, only 200,000 stay in the hospital more than two months. Under the "catastrophic coverage" proposal, an average hospital stay of eleven days would cost the beneficiary nearly twice as much as under current law;

Introducing a "voucher system" for Medicare beneficiaries—as an incentive to purchase private insurance in lieu of Medicare.

The introduction of a voucher system is contrary to the premise of the Medicare program, which was designed to provide medical security for older Americans. How many carriers will be willing to insure the chronically ill 85-year-old patient? At what price? Having to purchase private insurance, even if it were obtainable, is a proposal which is unaffordable and unacceptable to older Americans.

Establishing a "means test" for Medicare beneficiaries who would have to prove impoverishment in order to be eligible.

Health care is not just another private commodity bought by those who can afford it—it is a basic right and a necessity for all. Means-testing undermines basic principles of the Medicare program and thereby erodes the social compact between the government and the people.

Freezing Medicare reimbursement rates to physicians—unless accompanied by mandated assignment.

Recent legislation which places a 15-month freeze on physician reimbursement is highly controversial and questionable in terms of its impact on the Medicare beneficiary. It is our fear that many physicians will choose to "opt" out of the Medicare program, an option which in our view should not be available to them. We will monitor the physician freeze carefully to assure that the incentives to participate in the program are implemented and the penalties for non-compliance are enforced.

Finally, we oppose any efforts toward the creation of a bipartisan commission to address the Medicare funding problem. We advocate public hearings, allowing for maximum constituent participation in the decision-making process. Bi-partisan commissions make it easy for Congress to avoid public accountability.

JPAC supports the following:

1. Enactment of strong cost-containment legislation for the whole health care system—including doctors, hospitals, and other providers. Provisions for health-system cost control are embodied in the Medicare Solvency and Health Care Financing Reform Act of 1984, sponsored by Senator Kennedy (S. 2424) and Representative Gephardt (H.R. 4870). JPAC supports this bill and urges you to put your full support behind it.

2. Mandated Medicare assignment for all physician payments. Today, only 18.9% of physicians accept all of their Medicare patients on assignment, forcing the elderly to pick up a large share of the out-of-pocket costs. JPAC was extremely disappointed that last year, the House rejected a proposal to mandate assignment coupled with a freeze on physician fees for in-patient services. We actively support Congressman Roybal's bill H.R. 5169, the Medicare Physician's Fair Payment Act of 1984, which would make Medicare assignment mandatory. Unless providers accept part of the burden of health care costs, there will be no equitable solution to continued health care inflation.

3. Improved Medicare benefits, to include coverage for prescription drugs, eyeglasses, home care, hospice, dental care, and foot care. We strongly urge the development of a comprehensive program to meet the changing long-term care needs of the growing frail elderly population, with options and reimbursement ranging from community-based to institutional care.

4. Improved coverage for preventive care—through education and coverage for preventive checkups.

5. JPAC recognizes that in the long run, the solution to the nation's health care needs is a universal national health care plan with comprehensive coverage and benefits for all, cost and quality controls, annual budgets, and a reorganized health delivery system, such as embodied in H.R. 3884—the "Health Service Act" introduced by Congressman Ronald V. Dellums. Access to quality health care is still very much a problem for the nearly 40 million people who have no health coverage in the United States. A national care plan is the only way to eliminate this problem.

While we realize that a national health care program may not be politically viable at this time, we will continue our advocacy efforts in this area, and hope for your support toward this end.

In conclusion, we thank the Health Subcommittee of the House Ways and Means Committee for holding these hearings on Medicare financing and reform, and hope that you will seriously consider our recommendations. The elderly of this nation cannot afford to fall victim to the ailing health care system. We must work together to institute equitable health care reform without penalizing Medicare beneficiares.

Thank you.

Statement of the National Association of Manufacturers

The National Association of Manufacturers is pleased to submit the following statement for the record in response to hearings being conducted by the Subcommittee on Health of the Committee on Ways and Means. Our remarks address H.R. 4870, legislation introduced by Congressman Richard Gephardt (D–MO) in February of this year.

The NAM is a voluntary business association of over 13,000 corporations, large and small, located in every state. Eighty percent of the firms are considered to be small businesses. NAM member companies employ 85 percent of all workers in manufacturing and produce over 80 percent of the nation's manufactured goods. NAM is affiliated with an additional 158,000 businesses through its Associations Council and the National Industrial Council.

PROPOSED HEALTH CARE REFORM LEGISLATION

As noted by its sponsors, the intended purpose of the "Medicare Solvency and Health Care Financing Reform Act of 1984," H.R. 4870, is to ensure the fiscal soundness of the Medicare Hospital Insurance Trust Fund with no reduction in benefits or increase in taxes. At the same time, the legislation proposes to slow the excessive rate of inflation affecting other government health programs and employer health spending. Mr. Gephardt, key sponsor of the bill in the House, and the other co-sponsors are to be commended for bringing the cost problem to the attention of the Congress and encouraging dialog on this very complex subject.

The NAM agrees that Medicare and private sector health costs are growing at alarming rates and believe that major action is necessary. While some of the elements proposed in H.R. 4870 may encourage cost savings, others through regulatory mechanisms would serve to stifle much of the reform already underway in private

as well as public arenas. Our testimony will comment on specific portions of H.R. 4870 in this regard, particularly as it responds to marketplace changes occurring in our nation's health system, and as it responds to the impending Medicare crisis. Finally, we will present some recent examples of the private sector's experience in managing costs and comment on the timing of this legislation.

HEALTH CARE SYSTEM DYNAMICS

The Medicare Solvency and Health Care Financing Reform Act is broad in its intent, seeking to impact public as well as private health delivery. This broad mandate is influenced by a complex set of demographic, social, and economic factors. A growing elderly population is simultaneously placing increasing demands on the Medicare program and private employers. Those over 65 now comprise 11.3 percent of the U.S. population and by 2025, this group will grow to 19.5 percent. The number of workers per Medicare beneficiary (SS beneficiary) is now six, which will drop to two workers per beneficiary by 2025. Longevity gains are also swelling the ranks of Medicare eligibles.

American workers have routinely come to expect rich health benefit packages. As medical costs grew more slowly in the 1960s and early 1970s and employers wished to attract needed labor, they enhanced medical coverage. Once granted, such benefits were difficult to reduce, even in the face of subsequent economic recession. The growth of dual wage-earner families has made much of traditional health coverage nearly obsolete. At the same time, employer health costs have been rapidly rising, with nearly $100 billion paid out in 1983. Since the late 1970s, premiums have been going up 20 percent annually.

In response to the changing demographics and the cost escalation, over 200 corporations have begun offering flexible benefit plans which enable employees to select from a range of as well as a combination of benefits including medical coverage, dependent care, legal assistance, life insurance, and others. Employers are realizing cost savings from this approach. Pepsico, Inc. found that for those employees under its flexible benefit plan, medical care expenses rose only 9% a year compared to 17% a year for employees not covered by the plan.

American consumers have come to expect the highest quality medical care, irrespective of price since most care is paid by a third party or insurer. Rising incomes have created high expectations by consumers, and physicians traditionally have strived to provide all that is medically possible to the patient, regardless of the marginal cost benefits of the procedure, drug, or therapy.

In this environment, new technologies, including sophisticated diagnostic equipment and surgical techniques have flourished. However, this nation is fast approaching a period of scarcity with the need to set priorities for uses of technology, as Henry Aaron and William Schwartz point out in their recent book, "The Painful Prescription." The authoris compare American and British health care and note how kidney dialysis and other technologies are selectively rationed in the latter country.

The National Health Service of Great Britian is a heavily regulated system that controls spending through limiting hospital budgets. Limits and delays are also placed on the numbers of patients receiving all but emergency treatment. This is not to suggest that the U.S. will ration care in the British manner, but there is a concern that regulation in this country could transfer the focus for making health care decisions from the consumers and payers (and physicians) to the government. A regulated system can easily become politicized and result in a system in which certain institutions and groups of individuals fare better than others.

The dynamics shaping health care delivery—a growing elderly population, soaring employer premium costs, expanding medical technology, and diminishing public health budgets pose a challenge for policymakers. Certainly it will be tempting to look for easy solutions, but answers must not ignore or favor the concerns of one group over another. For example, the Advisory Council on Social Security has recommended a delay in eligibility for Medicare, an action that could cost the Chrysler Corporation alone, $100 million in added retiree benefits over the next five years.

MARKETPLACE CHANGES

The introduction of H.R. 4870 presumes that major health care reform is needed and we would not quarrel with that premise. We believe, however, that reform is already underway without legislative mandate. Recent marketplace changes are occuring in the way health care is financed, delivered, and sold to consumers.

Enrollment in health maintenance organizations (HMOs) has grown from less than 2.5 million persons in 1970 to over 12 million in 1983 with plans covering 42

states, the District of Columbia and Guam. Employers are seeing major savings with HMOs in some areas of the country. Ford Motor Company estimated it saved $5 million in 1982 and $7 million in 1983. While federal mandates played an early role in providing seed money for some plans, it is the investor community that now provides capitol to develop HMOs. Additional federal involvement, through the creation of incentives to use HMOs such as that mandated under H.R. 4870, is not needed. Successful HMOs should survive on their own merits, and not at the expense of other alternatives.

Preferred provider organizations (PPOs) are financing arrangements which offer cost saving incentives for both consumers and providers. In exchange for prompt bill payment and a guaranteed volume of patients, hospitals and physicians agree to reduce their fees. Consumers who agree to use these providers pay little or no copayment, but they are still free to use other physicians and hospitals at increased cost. Stouffer Foods in Cleveland, Ohio which began its PPO less than a year ago, is already seeing cost savings. The company is monitoring its experience through analysis of data on physician charges, lab procedures, and hospitalization charges by particular physicians.

Marketplace changes also include the growth of free standing "emergi-centers" providing emergency and primary care, and ambulatory surgery centers individually sponsored by hospitals and physicians.

Competition is indeed fierce in the health care industry. According to the Bureau of Television Advertising, health care professionals spent $41 billion on TV spots in 1983 compared to $3.7 million in 1977. Physicians are expanding office hours and aggressively marketing their services, Dr. Carl Myers of Platte City, Missouri, estimates he will spend $6,000 this year on thank you letters pamphlets and other advertising to new patients. To attract obstetrical patients, St. Joseph's Hosptial in Flint, Michigan offers expectant mothers a package called, "Special Delivery." This 24-hour hospital stay with follow-up visits sells for $799 compared to the normal delivery charge of $2,500 to $3,000.

So strong is the need to compete, that the National Association for Hospital Development and the American Marketing Association in April of this year held a history making conference entitled: "Seizing the Competitive Initiative: Strategic Planning in the Health Care Field." Keynoter Melvin R. Goodes, Executive Vice President of the Warner-Lambert Company, opened with the following statement:

"Ten years ago, even five years ago, the idea that hospitals and other health care institutions might actually think about, worry about and participate in competition with other hospitals and health care institutions would have been called a fantasy by some, a nightmare by others. It is no longer either. It is reality."

The marketplace changes being implemented by the provider community are in direct response to the pressures being exerted by the federal government through legislative changes, which we address in a later section. The private payers—the business community—have acted within the framework of the market system to deal with their cost problems. Private employers have formed over 150 business coalitions aimed at developing and implementing health cost management strategies that inlcude health planning, hospital trustee education, corporate wellness programs and data collection and analysis.

In 1982, the South Florida Health Action Coalition, through collection of data from 70 hospitals in Broward and Dade Counties, was able to develop hospital specific profiles on charges by diagnosis. Coalition members in turn are using this information directly or through their insurance carriers in negotiating rates.

The Houston Area Health Care Coalition with 39 corporate members is developing a data base detailing such items as hospital admissions, average length of stay, the cost of common medical procedures, and information on specific physicians, clinics, and hospitals. This utilization data will subsequently be shared with the public, including private companies, health planning experts, government officials, and other interested parties.

Individual companies are operating employee education programs designed to counsel workers on how to use their health benefits more wisely. Pratt and Whitney initiated a medical information service for employees and their family members by providing assistance on impending surgery and on medical questions. In 1981, the program showed a documented savings to the company of more than $200,000 and $50,000 to employees in out-of-pocket savings.

PRIVATE SECTOR COST MANAGEMENT EXPERIENCE

Employers, through coalitions, and individually at the company level, are actively working to bring health spending under control. In addition to participation in

HMOs and PPOs as described earlier, companies have made benefit plan design changes, utilized competitive bidding among carriers, and implemented other cost saving approaches.

As an incentive to hold down utilization, many employers are introducing and or improving consumer cost-sharing in their health benefit plans. Hewitt and Associates in Houston reported that of the plans surveyed in 1979, only 14% included deductibles; this figure climbed to 17% in 1982 and 32% in 1983.

To point to just a few examples of companies making major plan changes, we would call your attention to the following:

Exxon Company, USA which has always included some form of cost-sharing has recently expanded its deductible base and increased the stop loss amount. These changes are estimated to save the company and the plan participants 4.7 percent annually on medical costs. Given that the plan covers some 25,000 participants and their families, this is a considerable savings.

Nelson Industries, with eleven facilities in Wisconsin, manufactures mufflers, filters and silencers. Two years ago the company made major changes in its plan covering 1,036 employees. An analysis of their utilization revealed that claims were excessively high for routine care of spouses and children. In response, Nelson Industries expanded co-insurance and deductibles across the board. To soften the blow, the company increased its premium share from 60 to 70 percent. As a result, premiums have dropped five to seven percent with a total cost reduction of 30 percent in claims costs.

DuPont Company, which provides health benefits for its 400,000 employees, dependents and retirees, had traditionally offered hospital/medical/surgical coverage through 48 Blue Cross/Blue Shield plans. A single carrier had provided administrative services for all company locations. The introduction of MEDCAP, or Medical Care Assistant Program in 1981-82 made a major change by providing incentives for employees to be better health care consumers. On hospital care, the company introduced a 10 percent co-pay which could be avoided or reduced by employee use of second opinions on surgery, preadmission testing, alternative facilities such as birthing centers, and other options. Secondly, the Company opened up its administrative contract to competitive bid. Two commercial carriers now furnish services, providing ongoing competitive comparison as well as an emergency back-up system. On administrative costs alone, DuPont has seen a 40 to 50 percent improvement. It regularly shares such information with both carriers.

Numerous other companies such as Goodyear Tire and Rubber, Xerox Corporation, Honeywell, Inc. are making or have made major plan design changes. Their stories are daily being told by the media and we will not repeat them here. Suffice it to say that both large and small employers are taking positive steps to manage their health costs and they are doing so in the absence of specific regulatory controls. Legislating federal/state cost targets would, we believe, remove the incentives now motivating private employers.

MEDICARE PROGRAM

Estimates vary on exactly when Medicare's Hospital Insurance Trust Fund will become insolvent, but even the most optimistic economic assumption, according to the 1984 Medicare Board Trustees Report, projects that bankruptcy will occur in 1995. That impending insolvency and the program's current operation and status is a priority issue for the business community because: Program financing for the hospital insurance (HI) trust fund is through a payroll tax shared equally by workers and employers; employers supplement Medicare for their retirees and are now required to be primary payers for active workers aged 65–69 who so elect their employer's plan; and health care payments made by the federal government have a profound influence on the private health care market, since federal reimbursement most often does not cover full costs and so cost shifting to the private sector inevitably occurs.

Over the last few years, Congress has recognized Medicare's cost problems with legislative reform. The Tax Equity and Fiscal Responsibility Act (P.L. 97–248) of 1982 (TEFRA) made program cuts over a three year period of $13.3 billion through capping the annual growth of expeditures per case and limiting ancillary costs. The Deficit Reduction Act of 1984 requires a physician fee freeze.

In 1983, the Social Security Amendments (P.L. 98–21) mandated prospective budgeting for hospitals through a system of diagnosis-related groups (DRGs). This change has been heralded as the most revolutionary change since the passage of the Medicare and Medicaid programs in 1965 and 1966. Hospital that can deliver the service for the government set price per diagnosis or DRG will break even or will make

money if they can provide the service for less. The less efficient hospital whose costs exceed the DRG price will loose revenue.

By October of this year all 6,000 of the nation's hospitals will be covered by prospective payment. Already the impact is evident. Elliott White Springs Memorial Hospital in Lancaster, South Carolina, cut 6 of its 21 management positions and asked other salaried employees to take a 10 percent pay cut. And the Washington Hospital Center in Washington, DC announced its intent to close 100 to 115 beds (out of its 922 beds) and lay off 100 to 125 employees by May 15 in anticipation of the Center's coverage by DRGs in July.

Nationally, a survey of 20 states reported in the "American Medical News" indicated that 16 states reported hospital layoffs within the past six months. Much of the staff reduction was attributed to decline in patient days due to shorter lengths of stay. From these brief examples, it appears that DRGs have only begun to influence how health care is financed and delivered in this country.

The Advisory Council on Social Security in its report to the President earlier this year estimated that the trust fund would incur a $200–300 billion deficit by the year 1995. A number of financing and benefit changes were recommended in their report which we will not restate here. The NAM has studies the recommendations with a view toward balancing the needs of beneficiaries against an already considerable burden borne by the tax-paying public.

H.R. 4870 calls for certain modifications in the prospective payment law. Integrating the hospital and physician payment offers some opportunities for cost savings. The studies on physician DRGs being conducted by the Health Care Financing Administration will be important in determining the feasibility of this approach. Also called for by the legislation are limits on reimbursement for admissions increases above a base level. This provision would reduce incentives for unnecessary hospital admissions, an issue not addressed in the current law (P.L. 98–21). Finally, the proposed provision on mandatory assignment for Medicare services may actually reduce access to care for some beneficiaries. Rather, we would suggest offering incentives to health providers to accept assignment as a way to deal with this issue.

THE ADVISABILITY OF FEDERAL COST CONTAINMENT LEGISLATION

The Medicare Solvency and Health Care Financing Reform Act, while offering several constructive amendments to the prospective payment law, would not as a whole deal with the public and private sector health cost problem for these reasons:

Setting state cost targets would eliminate incentives for private employers and insurers to be economical health care purchasers.

Federal/State regulation of hospital rates would necessitate the establishment of a new bureaucracy with its attendant costs which would no doubt be borne by the taxpayers and could cause a resurgence in the cost rise.

A growing number of states—New York, New, Jersey, Massachusetts, Maryland, Maine, West Virginia, Connecticut to name just a few—are operating or are about to enact regulatory systems to control hospital costs. Others, such as California, are experimenting with a negotiated or competitive approach. States are demonstrating their ability to respond to the cost issue and federal mandates at this point could hinder this process. It should be pointed out that there is great variability across states. For example, Massachusetts with its many teaching hospitals and over abundance of physicians stands in sharp contrast to Montana, a rural state with few health care providers.

Excess beds have been the norm for a growing number of hospitals over the past few years. This factor in and of itself has spurred institutions to compete for patients with price incentives and enter into PPOs.

The physician supply has swelled by 38 percent in the past ten years and by 1990 there will be 600,00 physicians or 245 per 100,000 persons compared to 177 per 100,000 in 1975. This health manpower is already having an impact as practitioners look toward alternative financing and delivery systems to assure their incomes.

Implementation of the prospective payment law will soon include all eligible hospitals. With bed cutbacks, staff layoffs, and other competitive outcomes already occurring it seems especially important to study the impact on Medicare costs before making major legislative change.

Further, as has been pointed out earlier, private employers are engaged in a wide range of cost management activities. H.R. 4870 would stifle much of this plurality and creativity underway. While we would not argue that government should not be responsible for public program management such as implementation of prospective payment, we believe that the private sector provisions of the proposed legislation would not ultimately result in lasting cost containment. Rather, permit private em-

ployers to continue on their present course in using the competitive marketplace to realize savings. At the same time, we recognize the importance of the interplay between government and the private sector in this regard which is well summaried in the following statement by William Deans, Manager, Employee Benefits Section, DuPont Company:

"I conclude that business does have an opportunity to use economic competition as a management tool for cost containment. Government has a role to play also as a large purchaser. Whatever one might think of DRGs as a payment mechanism, I have seen significant changes in physician and administrative attitudes when faced with managing costs on a prospective, product line basis."

We believe that true cost savings can only be achieved through this public-private sector interplay. While we do not support enactment of H. R. 4870 for reasons noted previously, the NAM does offer its support to the Subcommittee in developing solutions to the Medicare crisis and the issues facing the broader health care system.

STATEMENT OF NATIONAL ASSOCIATION OF REHABILITATION FACILITIES, ALLEN COX, EXECUTIVE DIRECTOR

I am Allen Cox, Executive Director of the National Association of Rehabilitation Facilities (NARF). NARF is the national voluntary membership organization representing community based rehabilitation facilities. Our medical members include free-standing rehabilitation hospitals, rehabilitation units in general hospitals and comprehensive outpatient rehabilitation facilities. They serve over 500,000 disabled people a year who are suffering from the results of stroke, arthritis, spinal cord injuries, brain injuries and neuromuscular skeletal diseases among many others. Most if not all are providers under the medicare program. NARF is pleased that the subcommittee has continued to address the financing issues facing the medicare trust fund through this hearing, its previous hearing in April and the conference it sponsored with the Congressional Budget Office in November, 1983.

At the hearing on September 13, the Congressional Budget Office (CBO) gave its most recent estimates on when the Hospital Insurance trust fund would begin to experience a deficit. Under CBO's baseline assumptions the trust fund would start to run a deficit in 1994. This is several years later than its original estimate which showed it starting to experience trouble as early as the late 1980's. CBO outlined its assumptions and reasons as to why a deficit will not occur until several years later. CBO's conclusion is based on certain assumptions regarding inflation, implementation of the DRG system, admittance of the medicare population and others.

There are several other changes occurring which we believe will affect the medicare system. Many of these have been outlined in detail by other witnesses in their testimony before the subcommittee. NARF would like to highlight the following:

The increasing number of elderly in the population and the increasing number of frail elderly. Over the next 50 years the population over 65 will more than double and the population over 85 will more than triple.

There are an increasing number of advances in the area of medical technology which will allow individuals to be able to continue to be able to live to an older age.

In part, due to the increasing advancements and availability of medical technology, there will be an increasing number of elderly who may be living with a disability requiring some level of service.

For the current disabled elderly population, many require long-term care services and the vast majority of these services are provided informally by the family, usually the daughter or daughter in law.

Any examination of the medicare system should keep these factors will in mind. From NARF's perspective they highlight the need for medicare to recognize and continue to recognize rehabilitation within the health care delivery system and the important role it plays. Rehabilitations's objective has been, and is, restoring a disabled person to his or her maximum functional level and having that person return home and be independent. For many elderly disabled, rehabilitation will allow them to return to their home, as long as there are adequate home and community based support services available. For the increasing elderly population rehabilitation plays a vital role in: Restoring functional levels and independence; promoting prevention of disease and accidents and promoting the concept of the healthy elderly; and reducing long-term costs by preventing readmittances and institutionalization. For example, cost studies of stroke rehabilitation show considerable return of the investment and services. A patient who is not rehabilitated costs $92,736 in 1980 dollars more to support than rehabilitation patients living at home. The average cost of re-

habilitation services, a one time expenditure is $8,000 to $12,000. This expenditure results in a savings of $81,250 to $84,750.

NARF believes any examination of the medicare system to resolve the financing issues facing it should at a minimum: continue to provide coverage for rehabilitation services both in the inpatient and outpatient settings; provide a payment mechanism for uncompensated care and provide incentives for institutions to serve people without regard to pay; and provide coverage of long-term care services, primarily those that promote home and community based care when adequate support systems exist. This could be financed through a small premium.

NARF has examined several of the medicare financing reform proposals put forth. Our specific comments on two of these proposals are as follows:

H.R. 4870, MEDICARE SOLVENCY AND HEALTH CARE FINANCING REFORM ACT OF 1986

NARF has examined H.R. 4870 and applauds its sponsors for initiating a proposal addressing both the financing problems facing the medicare system and the overall problems of increasing health care costs.

We have several specific comments on the proposal and these have been given to the respective sponsors of the bill, Congressman Richard Gephardt and Senator Edward Kennedy. They are:

A. Section 2140(2) page 47

The definition of the term "hospital" excludes rehabilitation hospitals which are excluded from the medicare PPS system. Payment under the PPS is based on diagnostic related groups (DRGs). However, the methodology and data on which DRGs are based does not include any extensive data for medical rehabilitation. Therefore the Administration proposed to exclude them. Congress agreed that the inclusion of rehabilitation facilities in the DRG based PPS would be inequitable and unfair. We note that the residual federal program for private payers will utilize diagnostic related groups and that states may use a similar program.

While the bill proposes to exclude rehabilitation hospitals, we recommend that it be amended to exclude, in addition, a rehabilitation unit which is a distinct part of a hospital. Such units were also exluded from the PPS system under the Social Security Amendments of 1983. The rationale for the exclusion of hospitals is equally applicable to units. Therefore, we recommend that line 7-10 of page 48 be amended to read:

"(D) is a psychiatric hospital (as described in section 1861 (F)(1) of such Act), a rehabilitation hospital (as defined for purposes of section 1886(d)(1)(B)(ii) of such Act) or a rehabilitation unit which is a distinct part of a hospital (as defined for purposes of section 1886(d)(1)(B))".

B. Section 2103(c)(1)(B) pg. 15, section 2125(a)(1)(2) page 44

We support the requirement that state plans must provide a mechanism to pay for the unreimbursed cost of serving low income, uninsured or underinsured patients and that states may not refuse to admit patients because of inability to pay or who require extensive treatment.

Medicare and medicaid do not allow bad debts or charity allowances as part of reasonable cost. Most of our members are non-profit in nature are frequently required by their charters to accept patients without regard to their ability to pay.

These requirements address this problem which hospital's have been facing for years and addressing it only by shifting costs among categories of payers. We support them. C. Section 2102(c)(3)(A), pg. 6

This subparagraph provides incentives to states to establish a state health care plan by increasing the federal medical assistance percentage (FMAP). The FMAP will be increased by several percent if the state has an acceptable plan in effect. The incentive will be increased by an additional percent if the state has an unrestricted medicaid plan defined as one which does not impose any limitation in the scope or duration of inpatient hospital services (other than for medical necessity.)

We support giving states incentives to establish unrestricted plans. Many states have been restricting coverage for inpatient hospital services either by limiting the number of insured days or admittances as a reaction to the restriction of federal medicaid payments included in the Omnibus Budget Reconciliation Act of 1981. These actions adversely effect medicaid beneficiaries who need rehabilitation services and may require hospitalization beyond that covered under the medicaid plan. Our facilities are receiving referrals from short term hospitals frequently after the beneficiary's medical coverage has been exhausted. The facility has the choice of serving the person as a charity case, or not serving him or her. Therefore, we sup-

port recognition of the need to assure there are no arbitrary restrictions on hospitalization coverage.

S. 2752, MEDICARE INCENTIVE REFORM ACT

S. 2752 takes a different approach to controlling health care and medicare costs than does HR 4870. This approach has been characterized more as an incentive approach as opposed to a regulatory approach.

We support the following section of the bill:

Section 2102 which requires the state Health Care Efficiency Plan to provide a method of reimbursing hospitals for inpatient care to uninsured and underinsured patients;

Section 7 amending Section 1813 to limit the out of pocket costs for beneficiaries to $400 a year;

Section 8 providing for a catastrophic coverage for hospital stays under part A, however, we question a need for a trade off of catastrophic coverage with an increase in the premiums under section 9;

Section 10 which provides that the cigarette excise tax be doubled and the revenues from the additional tax be dedicated to the Hospital Insurance trust fund.

In addition section 2104(l) defines the term "hospital". It excludes from this definition under paragraph (C) "a rehabilitation hospital (as defined for purposes of Section 1886(d)(1)(B)(ii) of this Act)." This definition of the term "hospital" recognizes rehabilitation hospitals which are excluded from the medicare PPS system. For the reasons stated above we believe the bill should be amended to recognize and exclude a rehabilitation unit which is a distinct part of a hospital (as defined for purposes of Section 1886(d)(1)(B)). This would make it consistent with the exclusion currently allowed distinct part rehabilitation units form the medicare prospective payment system.

We would be pleased to provide any additional information to the committee.

STATEMENT OF THE NATIONAL CENTER FOR POLICY ANALYSIS, PETER FERRARA; JOHN C. GOODMAN; GERALD MUSGRAVE; AND RICHARD RAHN

SOLVING THE PROBLEM OF MEDICARE

Summary

Medicare is bankrupt. At the moment a small surplus exists in Medicare's Hospital Insurance Trust Fund, yet by any reasonable prediction, that surplus will vanish in a few short years as expenditures quickly outpace tax revenues. The deficit is not only a short-term liability; the long-term picture looks much worse. If the current spending trend continues, Medicare spending will account for one out of every three dollars in the budget 50 years from now.

The crisis of Medicare is much more than a budgetary crisis. It also has a human dimension, which is difficult to measure in terms of dollars and cents. Right now, Medicare is making implicit promises to millions of working men and women. The promise is that in return for the taxes these workers are paying into the system, government will pay for certain medical expenses during their retirement years. But, it is not at all certain that this promise can ever be met.

We propose an alternative to the present system—a plan whereby individuals would be allowed to make annual contributions to qualified individual retirement accounts called Health Bank IRAs. After a 30-year period, sufficient funds would accumulate in these accounts to allow individuals to pay for their own medical expenses and/or private health insurance. These individuals will have "opted out" of the basic Medicare program. They will rely on Medicare only in case of very large, catastrophic medical expenses.

The choice to opt of Medicare is voluntary. Individuals who choose the IRA option would be given tax credits for their Health Bank IRA and equal to the amount of the tax credit allowed other individuals.

Money deposited in a Health Bank IRA would be the private property of the individual who creates the account. Moreover, this money would be part of the individual's estate and would be passed on to his or her heirs. When individuals spend their Health Bank IRA money, they would be spending their own money, not someone else's. This new incentive alone should help reduce costs significantly.

THE MEDICARE BANKRUPTCY*

Medicare is bankrupt. At the moment a small surplus exists in Medicare's Hospital Insurance Trust Fund. Yet by any reasonable prediction, that surplus will vanish in a few short years as expenditures quickly outpace tax revenues. We estimate that:

Between now and 1995 the cumulative deficit in Medicare's HI Trust Fund will be $400 billion.[1]

This deficit is a liability equal to almost $2,000 for every man, woman and child in the country under the age of 65.

The deficit is only a short-term liability, however. The long-term picture looks much worse. Since 1967, spending on Medicare has grown from $3.4 billion to $57.4 billion—an increase of more than 1,500 percent! Over the last decade, spending on Medicare has grown at an annual rate of 17.7 percent. At this rate of growth Medicare outlays will double every four years. Even if the rate of growth moderates to the 14.4 percent predicted by the Congressional Budget Office, Medicare outlays will grow from seven percent to ten percent of the federal budget by 1988.[2] If this trend continues, Medicare spending will account for one out of every three dollars in the budget 50 years from now.

The crisis of Medicare is much more than a budgetary crisis. It also has a human dimension which is difficult to measure in terms of dollars and cents. Right now, Medicare is making implicit promises to millions of working men and women who are paying taxes into the system. The promise is that in return for the taxes these workers are paying, government will pay for certain medical expenses during their retirement years. Yet it is not at all certain that this promise can ever be met.

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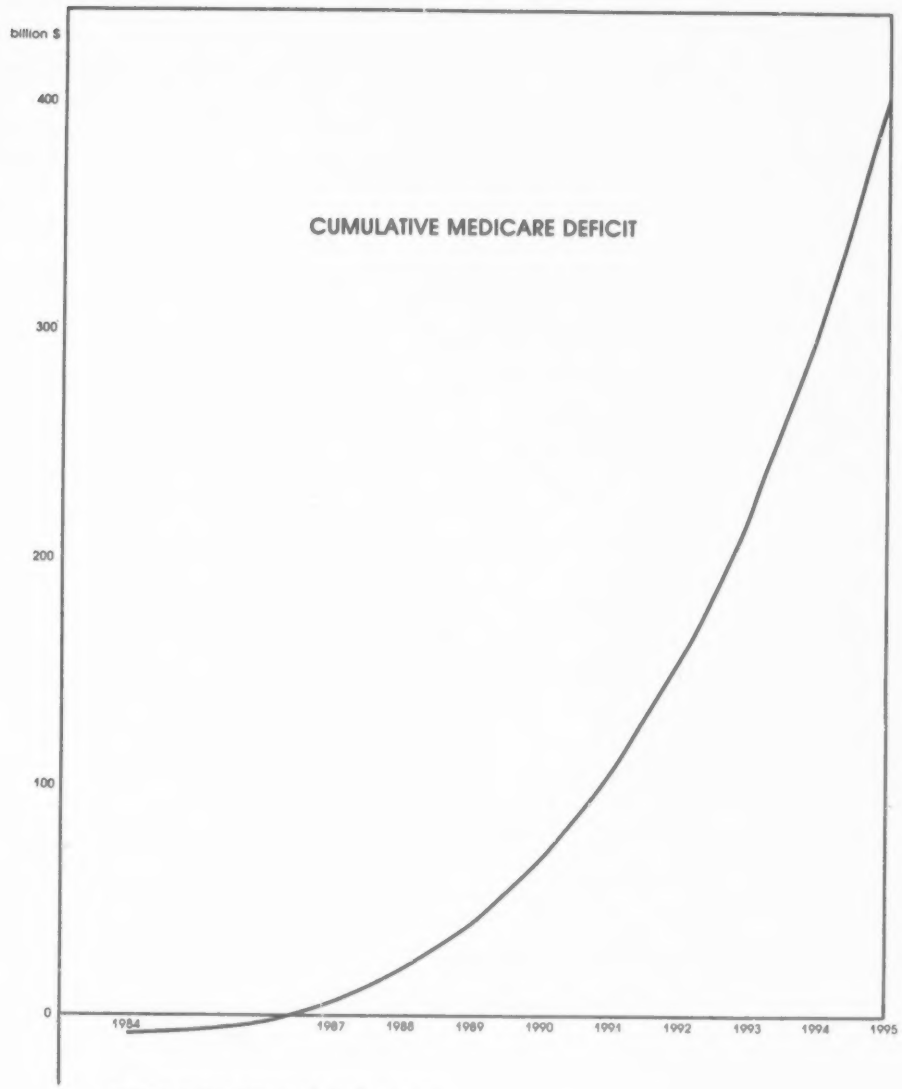
*The authors gratefully acknowledge the valuable assistance of NCPA staff members Robert Porter, Merrill Matthews and Sanyal Sabyasachi in the preparation of this report. We thank Dr. Jesse Hixson of the Health Resources and Services Administration who, together with Dr. Musgrave, developed the "health bank" concept. We thank the Cato Institute for its encouragement and support of this project.

[1] This estimate assumes that Medicare outlays increase at an annual rate of 13.7 percent and taxable payrolls increase at an annual rate of 6.8 percent.

[2] Congressional Budget Office "Changing the Structure of Medicare Benefits" (Washington, D.C.: CBO, March 1983), p. 2.



SOURCE: National Center for Policy Analysis

THE UNEASY CASE FOR MEDICARE

Because of record deficits, the federal budget is receiving unusual scrutiny to determine which programs have merit and which ones do not. As one looks down the list of spending programs, it is clear that various programs exist to meet fairly well-defined objectives. Some programs, for example, exist to help the needy. Some exist to help minority groups. Some are designed to provide for the national defense. Others are presumed to promote the general welfare.

Even within the category of federal spending on medical care, most programs exist to meet clearly defined social goals. Medicaid exists to provide medical care for the poor. Money spent on the V.A. hospital system presumably is part of our national defense effort. Money spent on medical research presumably promotes the general welfare.

Medicare does not fall within any of these categories. In fact, if one looks carefully at Medicare it is difficult to understand what the rationale is for this program.

1. Medicare beneficiaries did not pay for the benefits they receive

Medicare is an insurance policy which pays the medical bills of those who qualify as beneficiaries. In any given year, only a small percentage of beneficiaries will have substantial bills paid for by Medicare. On the average, about 78 percent of all Medicare spending pays for medical services used by only 11 percent of Medicare beneficiaries. About 40 percent of all beneficiaries generate no Medicare payments.[3] However, even those beneficiaries who had no medical bills during a given year derived something of value from Medicare. What they received was protection of their assets from unforeseen medical bills. They lived secure in the knowledge that had they generated unforeseen medical expenses, Medicare would have paid a substantial portion of those costs.

One way of thinking about the value of Medicare is to ask: What would a beneficiary have to pay to obtain a similar insurance policy in the private marketplace? Since private insurers have to charge premiums that are roughly equal to expected outlays, the cost of an insurance policy similar to Medicare would be roughly equal to the amount that Medicare spends per beneficiary per year. In 1982 this amount was about $1,819.[4]

A little known fact about Medicare is that the amount which beneficiaries have paid into the program in taxes is only a small fraction of the amount they are receiving and can expect to receive back in the form of benefits. For example, a male worker earning the median income who reaches age 65 today will receive more benefits in two years from Medicare than he paid in taxes over his entire working life.

Even if there is no increase in Medicare spending per beneficiary in the future;[5]

A male beneficiary, age 65, can expect to receive 10 times more in Medicare benefits than he paid in taxes.

A male, age 70, can expect to receive 21 times more in benefits than he paid in taxes.

A male, age 75, can expect to receive 53 times more in benefits than he paid in taxes.

A male, age 80, can expect to receive 291 times more in benefits than he paid in taxes.

If these beneficiaries have a dependent spouse, the expected benefits relative to taxes will more than double. .

Medicare, then, is a program which takes billions of dollars out of the pockets of some Americans and pays for the medical bills of other Americans. For those who are on the receiving end, the program has been a bonanza. Medicare beneficiaries are receiving far more in benefits then they ever paid in taxes.

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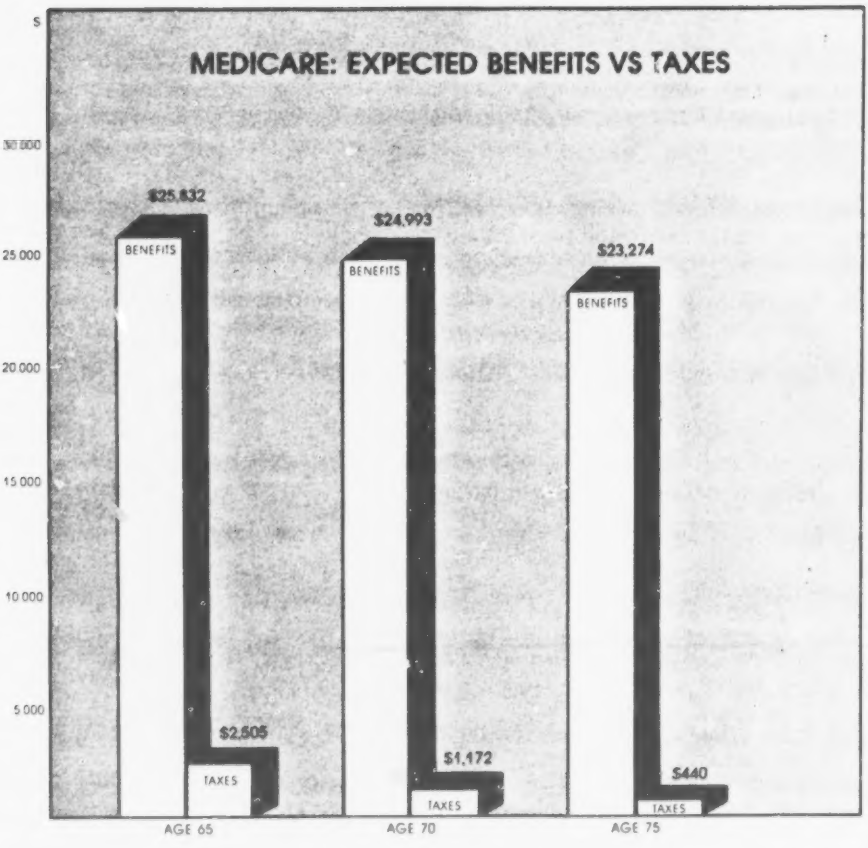
[3] Ibid, p. 17. See also Karen Davis, "Medicare Reconsidered," prepared for the Duke University Medical Center Seventh Private Sector Conference on the Financial Support of Health Care of the Elderly and the Indigent, Durham, North Carolina, Mar. 14-16, 1982. Quoted in the New England Journal of Medicine, May 27, 1982, p. 1310.

[4] Spending per beneficiary under Part A (Hospital Insurance) was $1,364 and net spending under Part B (Supplemental Medical Insurance) was $455.

[5] These estimates are based on the latest life expectancy statistics available from the National Center for Health Statistics. They assume the worker earned the median wage each year since Medicare was enacted and that he retired at age 65. The calculations ignore the time value of money.



SINGLE MALE WORKER

SOURCE National Center for Policy Analysis

2. Medicare beneficiaries are financially better off than medicare taxpayers

When the Medicare program was enacted in 1965, it was part of the "War on Poverty." Ever since it has been viewed as a poverty program. This perception is incorrect, however. Not only does Medicare not take from the rich and give to the poor; if anything, it does the reverse.

The after-tax income of the elderly ($6,300 per person in 1980) is greater than the after-tax income of those under 65 years of age ($5,910 in 1980).[6]

On the average, people over 65 have considerably more wealth than those under 65.[7]

Far from being a poverty program, Medicare, among other things, takes taxes from the working poor and pays for the medical bills of retired millionaires. It certainly cannot be justified on the grounds that it always promotes greater equality of income and wealth.

3. Medicare is unfair to minorities

A recently publicized fact about Medicare and Social Security is that both programs discriminate against minorities. This is because black and Hispanic Americans have lower life expectancies than white Americans. For example, the life expectancy of a black male at birth is six years shorter than it is for a white male. The life expectancy of a black female is about five years shorter than for a white female. Because the eligibility age for Medicare is the same for both races, whites get a much better deal from the program than do blacks and other minorities.

To see how much difference life expectancy makes, consider the following:

A black male at birth has a life expectancy of 64.8 years. Although he will pay taxes into Medicare throughout his working life, he can expect to die two months before he becomes eligible for benefits.

A Hispanic male at birth has a life expectancy of 66.6 years. A white male has a life expectancy of 71 years. Both pay the same payroll tax rates. Yet the white male can expect to receive Medicare benefits five times greater than those received by his Hispanic cohort.

Because black and Hispanic Americans have lower life expectancies than white Americans, members of these minority groups tend to be overrepresented among Medicare taxpayers and under-represented among Medicare beneficiaries:

More than 14.4 percent of the population of tax-paying age is non-white.[8]

Only 8.6 percent of elderly Medicare beneficiaries are non-white.[9]

It is interesting to compare the representation of minorities in Medicare (eligibility is based on age) with their representation in Medicaid (eligibility is based on income). Although only 8.6 percent of elderly Medicare beneficiaries are non-white, about two-thirds of all Medicaid beneficiaries are non-white.[10] It is also interesting to note that when it came time to slow down the growth of federal spending, it was Medicaid, not Medicare, which took most of the brunt of the belt tightening.

An NCPA study entitled "The Effect of the Social Security Reforms on Black Americans" [11] has documented that the recently legislated increase in the retirement age for Social Security will be devastating for blacks and other minorities. The Social Security Advisory Council has proposed that the eligibility age for Medicare also be raised. The Council has proposed to increase the eligibility age from 65 to 67 by 1990. If this proposal is adopted:

A black male, age 20, will lose 100 percent of his expected benefits under Medicare. His white counterpart will lose only 25 percent of his.

A black female, age 20, will lose 19 percent of her expected benefits. A white female will lose only 14 percent of hers.

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[6] U.S. Bureau of the Census, *Current Population Reports*, Series P-23, No. 126, "Estimating After-Tax Money Income Distributions Using Data From the March Current Population Survey," U.S. Government Printing Office, Washington, D.C. 1983, Table 1, pp. 20–23.

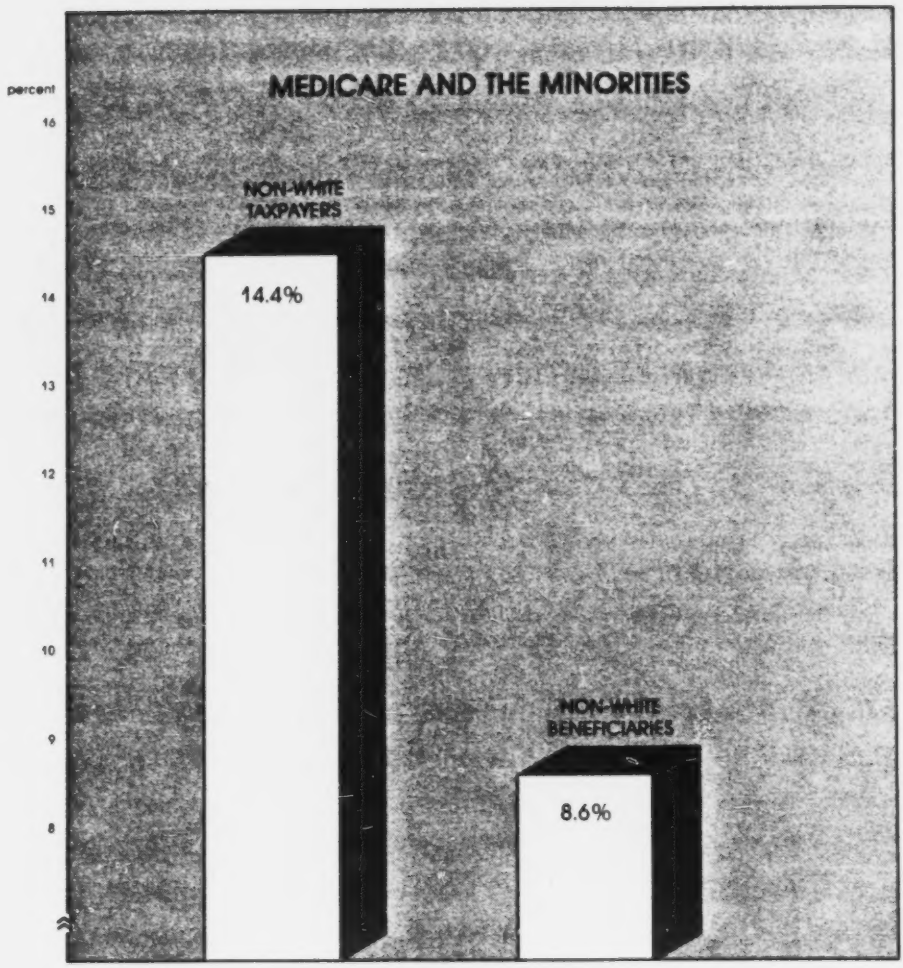
[7] Wall Street Journal, April 28, 1982, p. 30.

[8] U.S. Bureau of the Census, "Statistical Abstract of the United States: 1982–83", Washington, DC, 1982, p. 26.

[9] Department of Health and Human Services, "The Medicare and Medicaid Data Book, 1981," (Baltimore, Md., 1982), pp. 16–17.

[10] Ibid, p. 19.

[11] Staff Report, "The Effect of the Social Security Reforms on Black Americans," National Center for Policy Analysis, July, 1983.



SOURCE: National Center for Policy Analysis

Moreover, unlike the recent reforms in the Social Security retirement age, the Advisory Council's proposal would index the eligibility age for Medicare to gains in life expectancy. The probable effect of this change will be that blacks, expecially black males, can always expect to receive, on the average, virtually nothing from Medicare.

4. Medicare is unfair to the young.

Medicare, we have noted, has been a bonanza for those who are currently covered by the program.

A male worker earning the median income who reaches age 65 today can expect to receive $23,237 more in benefits than he paid in taxes.

If he has a dependent spouse the couple together will receive $56,982 more in benefits than they paid in taxes.

The enormous benefits received by today's Medicare beneficiaries are made possible by the taxes being paid into the system by the working population. Yet young workers who are paying Medicare taxes will never receive anything like the "deal" the elderly are receiving today. In fact, most young workers entering the labor force right now will pay considerably more into Medicare than they can expect to receive in return.

We have calculated the present value of Medicare for workers at different age levels under the conservative assumption that Medicare spending per beneficiary will grow no faster than the rate of growth of nominal wages. Under conservative assumptions: [12]

A white male, age 20, can expect to pay about $8,500 more in taxes than he will receive in benefits.

A black male, age 20, can expect to pay about $14,000 more in taxes than he will receive in benefits.

Moreover, almost anything that Congress is likely to do to relieve the financial crises of Medicare—raise the payroll tax, raise the eligibility age, raise deductibles or co-insurance rates, etc.—will lower the expected benefits to young workers and make the return on their Medicare investment even lower than it is now.

For example, under current law, the combined payroll tax on employers and employees is scheduled to rise from the current 2.6 percent to 5.08 percent by 1995. If, in order to reduce the Medicare deficit, Congress also raises the eligibility age to 67, the penalty imposed on young workers will be substantial:

With a 5.08 percent medicare payroll tax and an eligibility age of 67, a white male, age 20, can expect to pay about $33,171 more in taxes than he will receive in benefits.

Under the same conditions, a white female worker, age 20, can expect to pay about $6,685 more in taxes than she will receive in benefits.

5. The criteria for eligibility are arbitrary

Medicare, as we have seen, provides enormous benefits to those who currently qualify for coverage—benefits which far exceed the value of taxes paid. In view of this fact, it is interesting to consider what an individual has to do in order to be eligible for the lavish benefits which Medicare confers.

The basic requirement for eligibility is to reach 65 years of age. At 64 years 11 months, one gets nothing from Medicare. One month later, Medicare starts paying the medical bills. Aside from age, little else seems to matter.

You don't have to be poor to be covered by Medicare.—As we have seen, Medicare is not a poverty program. Thee are about 254,000 millionaires who are either covered by Medicare, or who can be covered if they choose to do so.[13]

You don't have to be retired to be covered by Medicare.—Unlike Social Security, you do not have to quit earning a living in the labor market in order to receive Medicare benefits. In principle, the president of Exxon can receive Medicare benefits—courtesy of the taxes paid by other Exxon employees.

You don't have to pay Medicare taxes in order to be covered by Medicare.—People over 83 years of age who are drawing Social Security benefits never paid one dime into Medicare. Yet these individuals have received thousands of dollars of benefits from the program.

Individuals reaching 65 today can also become eligible for benefits, even if they never paid taxes into the program. (These include federal workers, and employees of state and local governments and non-profit institutions which have elected to get

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[12] Present value calculations were made based on a rate of interest equal to the rate of growth of the average wage.

[13] Based on estimates made in U.S. News & World Report, October 3, 1983, p. 65.

out of Social Security.) They can receive Part A (Hospital Insurance) by paying a monthly premium of $113 and Part B (Supplemental Medical Insurance) for a monthly premium of $12.20.[14] These premiums are an exceptionally good deal for elderly individuals with known illnesses who face very expensive medical procedures.

You don't have to be a good citizen to be covered by Medicare.—Amazing as it may seem, you can break any number of laws and still be covered by Medicare. According to federal regulations, the only crime which gets an individual tossed out of Medicare is plotting an overthrow of the federal government, i.e. the people who give us Medicare.[15]

You don't have to be a citizen at all to be covered by Medicare.—Noncitizens who become permanent residents and remain in the United States or one of its territories for a period of five years can become eligible for Medicare.[16] For example, had he lived for a few more years the Shah of Iran could have been covered by Medicare!

THE LONG-TERM PROBLEM OF MEDICARE: A CRISIS IN FUNDING

Like Social Security, Medicare is viewed by most people as a government insurance program, fully comparable in concept to a private insurance plan. This image is encouraged by numerous publications of the Department of Health and Human Services and by the public pronouncements of leading politicians and bureaucrats.

Payroll taxes which fund Medicare are called "contributions." The surplus of taxes over expenditures is said to "accumulate" in a "trust fund." People are led to believe that the benefits paid out by Medicare are "in return for" contributions made during their working years. If officials of a private health insurance company made claims about their policies which were as inaccurate as the claims routinely made by government officials about Medicare, the private officials would be violating numerous laws and would risk possible imprisonment.

In fact, the Medicare "trust fund" is largely a myth. There is no money being stored away in bank vaults for use during some later period. Every dollar paid into Medicare is spent by the federal government the very hour of the very day that it arrives.

Private insurance companies, by contrast, are required to keep an actual fund of assets from which to pay claims. They cannot simply write IOUs to themselves and spend the money elsewhere. Moreover, the benefits paid by private insurance companies are financed by the premiums paid by the policyholders.

By contrast, money paid into Medicare by today's workers is not invested in assets and kept there until those workers reach the age of 65. Money paid into Medicare by today's workers is spent immediately on benefits provided to today's beneficiaries. Today's workers, then, are not paying for their own benefits. They are paying for someone else's benefits. Any benefits which today's workers hope to get from Medicare during their retirement years will have to be paid for by the next generation of workers. It is for this reason that Medicare, like Social Security, is properly referred to as a "pay-as-you-go" system.[17]

One of the inherent problems of any pay-as-you go pension or health care system is that each generation of workers depends on the ability and willingness of the next, yet-unborn generation of workers to pay its benefits. Yet no one really knows how many members of the next generation there will be or what type of burden they will be asked to bear. More important, no one knows what the next generation of workers will be willing to pay. Medicare, as we have seen, has been a bonanza for workers who are 65 years and older today. But each new generation of workers can expect to pay more in taxes than they will receive in benefits. Why should the next generation of workers support a system which they never consented to and from which they can never realize a positive gain?[18]

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[14] Commerce Clearinghouse, Inc., "Medicare and Medicaid Guide" (Chicago, IL, 1983), p. 739 and p. 3050.

[15] Treason is the only crime which disqualifies a person from Medicare coverage. However, any imprisonment will suspend Medicare benefits during the term of imprisonment because the institutions are obligated for the medical services of their inmates.

[16] Commerce Clearinghouse, Inc., "Medicare and Medicaid Guide" (Chicago, IL, 1983), p. 1405.

[17] For a non-technical discussion of the pay-as-you-go nature of our Social Security system, see John Goodman and Edwin Dolan, "Economics of Public Policy" (St. Paul, Minnesota: West Publishing Co., 1982), 2d. ed.

[18] For a more complete discussion of the nature of the Social Security crisis see Peter Ferrara, "Social Security: The Inherent Contradiction" (San Francisco: Cato Institute, 1980), and A. Haeworth Robertson, "The Coming Revolution in Social Security" (McLean, VA: Security Press, 1981).

Just how bad things can get in the future is shown in the calculations recently made by Haeworth Robertson, former Chief Actuary of the Social Security Administration. Robertson calculated the potential burden of Social Security and Medicare for future generations of taxpayers using three sets of assumptions used by the Social Security Administration: optimistic, intermediate and pessimistic. Since Social Security's pessimistic assumptions historically have been far closer to reality than the two other sets of assumptions, Robertson's predictions based on these is the most interesting.

Robertson estimated that under pessimistic assumptions, in order to pay for Social Security and Medicare benefits 70 years from now the government will have to collect between 40 to 50 percent of income in the form of payroll taxes.[19] Moreover, the pessimistic assumptions are by no means the worse thing that can happen. These assumptions, for instance, ignore the possibility of major breakthroughs in slowing down the process of aging.

Some scientists are now predicting that the average life span may be extended from the current level of 74.5 years to 150 years by the turn of the century.[20] If life extension occurs by increasing productive years relative to retirement years, the long-term problems of Social Security and Medicare will ameliorate. If, on the other hand, life extension occurs largely by increasing the retirement years, the problems of Social Security and Medicare will become much worse. We could face a situation in which as much as 60 to 70 percent of taxable payroll is needed to pay promised benefits.

The real long-term funding problem of Medicare, then, is that by continuing the pay-as-you-go system we are putting children today at great risk. We have no real assurance that when these children reach the age of 65, the working population will be willing or able to pay promised benefits.

Prudence demands that we act now to relieve this risk.

THE LONG-TERM PROBLEM OF MEDICARE: WASTE AND INEFFICIENCY

A major difference between Medicare and Social Security is that under Social Security money is given directly to beneficiaries. This means that when Social Security beneficiaries spend their Social Security dollars on goods and services, the money they spend they treat as their own.

By contrast, money spent under Medicare goes to someone other than the beneficiary—doctors, hospitals, and other health care providers. Medicare beneficiaries do not have the option of taking their benefits in cash and putting them in the bank. Thus, when Medicare beneficiaries spend a dollar on medical care, that is not a dollar that they could have spent on other goods and services. This means that Medicare beneficiaries are not spending their own money when they make purchases in the health care marketplace. Instead, they are spending someone else's money.

This difference between Medicare and Social Security has a substantial impact on the incentives faced by the elderly. If an elderly person is frivolous and wasteful in spending his Social Security dollars, he bears the full cost of that waste. If he is thoughtful and careful he bears the full benefit of that care. When spending Medicare dollars, however, things are very different. If a beneficiary is frivolous and wasteful in spending Medicare dollars, that cost is borne by someone else. If he is frugal and careful, the benefit of that care is realized by someone else. Small wonder, then, that one rarely hears much about wasteful spending of Social Security benefits, while one hears a great deal about wasteful spending in Medicare.

One example of an area where there is great potential for waste is in care given to patients who are near death. Of course, we do not always know in advance what the effects of medical treatment will be. Still, one cannot help but be amazed by the fact that:[21]

Twenty-eight percent of all Medicare spending is for the treatment of patients in the last year of their lives.

Eleven percent of all Medicare spending is for the treatment of patients in the last 40 days of their lives.

If Medicare patients were spending their own dollars, it is not at all clear that they would choose to deplete their estates by spending enormous sums of money to prolong life only marginally. On the other hand, if one has the opportunity to spend

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[19] Robertson, "The Coming Revolution in Social Security," p. 90. Robertson's calculations were based on an eligibility age of 65.

[20] See, for example, the interview with Dr. Roy Walford, UCLA Medical School, in U.S. News & World Report, July 4, 1983, pp. 73–74.

[21] Data obtained from the U.S. Department of Health and Human Services.

someone else's money to achieve marginal benefits, there is no economic reason not to do so.

The Medicare program leads to a great deal of waste and inefficiency because the purchasers of medical services do not bear the costs or reap the benefits of their decisions. There also is waste and inefficiency because the providers of medical services find it in their economic self-interest to increase spending under the program.

Much has been said about the way in which Medicare's cost-based reimbursement systems gives the providers of medical care incentives to increase their costs. Some believe that the new diagnostic related groups (DRG) system will give greater incentives to the providers to curtail the growth of Medicare spending.

Space does not permit an evaluation of these issues here. We do feel compelled, however, to make a general observation. Any Medicare reimbursement scheme, no matter how it is structured, will always be defective because consumers will always be spending, and the providers will always be receiving, someone else's money. The inherent defect in Medicare is that the decision makers can never be made to bear the full costs of their bad decisions.

THE HEALTH BANK IRA

The long-term problems of funding and inefficiency in Medicare necessitate radical reform. In designing a plan for such reform, we are guided by two principles:

Principle One: Given appropriate government policies, most individuals can be and should be responsible for paying for their own medical care during their retirement years.

Principle Two: In order to achieve an efficient allocation of resources in the health care marketplace, individuals whenever possible should bear the costs and reap the benefits of their own decisions.

We propose a system in which individuals will be allowed to make annual contributions to qualified individual retirement accounts called Health Bank IRAs. After a 30-year period, sufficient funds would accumulate in these accounts to allow individuals to pay for their own medical expenses and/or to purchase private health insurance for their retirement years. These individuals will have opted out of the basic Medicare program. They will rely on Medicare only in case of very large, catastrophic medical expenses.

The choice to opt out of Medicare is voluntary. However, individuals who choose the IRA option will be given tax credits for their Health Bank IRA contributions. We calculate that a tax credit of $500 per person will be sufficient to encourage all members of each new generation of workers to choose the private, IRA alternative to Medicare.

We propose to make these tax credits refundable. This means that individuals with no earnings will be able to get an income tax refund equal to the amount of the allowed tax credit. The refund will be placed in their Health Bank IRAs. This will give individuals with little or no income, living in poverty, a source of funds from which to purchase their own medical care during their retirement years.

Money deposited in a Health Bank IRA is the private property of the individual who creates the account. Moreover, this money is part of the individual's estate and can be passed on to his heirs. As a result, when individuals spend their Health Bank IRA money, they will be spending their own money, not someone else's.

The full details of this proposal are included in the Appendix to this report.

BENEFITS OF THE HEALTH BANK IRA PROPOSAL

This proposal eliminates for each new generation of workers the risk that succeeding generations will refuse to pay, or will inadequately pay, for their medical care during their retirement years. It allows all individuals to provide for their own medical care later in life from income earned during their working years. This proposal, therefore, solves the long-term funding problem which Medicare faces.

In addition, under this proposal individuals will be spending their own money for medical care. This means that individual IRA owners will have ideal incentives to weigh carefully the costs against the benefits of purchases of medical services and to avoid wasteful and inefficient spending.

Finally, because this proposal will lead to the phasing out of Medicare (except for catastrophic coverage) it will reduce the size of government income transfers which go from the working population to the elderly. This development should do much to improve the self-esteem of elderly citizens, most of whom do not relish being a burden on the young, and to reduce the economic and political tensions between generations.

On the average, workers today are paying about $464.10 per year into Medicare. This money is not kept in separate accounts for the workers who pay it. Instead, this money is spent on the medical care of other people. And the fact that it is spent does not mean that there is no way to assure that today's workers will have their medical expenses paid for during their retirement years.

Table I shows what would happen if a 20-year-old worker were allowed to invest his Medicare taxes in a private IRA account rather than pay the money into Medicare.

By the time the worker reached the age of 65, his IRA account would contain $476,519.

By the time the worker reached the proposed eligibility age of 67, his IRA account would contain $575,419.

This fund should be more than adequate to pay for medical care and/or private health insurance during the retirement years.

NOTE: Nothing written here is to be construed as necessarily reflecting the views of the National Center for Policy Analysis, or the organizational affiliations of the contributors, or as an attempt to aid or hinder the passage of any bill before Congress.

TABLE I.—WHAT MEDICARE TAXES WOULD GROW TO IF THEY WERE INVESTED IN AN IRA ACCOUNT

Year:	Amount deposited	Total accumulated
1 [1]	[2] $464.10	$505.86
2	487.31	1,081.35
3	511.70	1,731.09
4	537.25	2,487.29
5	564.12	3,318.31
6	592.32	4,265.07
7	621.94	5,323.22
8	653.04	6,520.60
9	685.68	7,857.21
10	719.97	9,364.97
11	755.97	11,013.09
12	793.77	12,869.49
13	833.46	13,704.87
14	875.13	15,895.42
15	918.89	18,327.30
16	964.83	21,028.37
17	1,013.07	24,021.81
18	1,063.73	27,340.13
19	1,116.91	31,020.44
20	1,172.76	35,090.60
21	1,231.40	39,592.37
22	1,292.97	44,567.52
23	1,357.61	50,057.82
24	1,425.49	56,114.33
25	1,496.77	62,792.73
26	1,571.61	70,162.63
27	1,650.19	78,279.74
28	1,732.70	87,209.03
29	1,819.33	97,038.66
30	1,910.30	107,856.84
31	2,005.81	119,747.00
32	2,106.10	132,820.00
33	2,211.41	147,189.00
34	2,321.98	162,973.00
35	2,438.08	180,298.00
36	2,559.98	199,317.00
37	2,687.98	220,192.00
38	2,822.38	242,942.00
39	2,963.50	267,887.00
40	3,111.67	295,232.00
41	3,267.26	325,194.00
42	3,430.62	358,029.00

TABLE I.—WHAT MEDICARE TAXES WOULD GROW TO IF THEY WERE INVESTED IN AN IRA ACCOUNT—Continued

	Amount deposited	Total accumulated
43	3,603.15	393,997.00
44	3,782.26	433,385.00
45 [3]	3,971.37	476,519.00
46	4,169.94	523,736.00
47 [4]	4,378.44	575,419.00

[1] Worker enters the labor market at age 20.
[2] Average combined employee and employer tax in 1983.
[3] Worker reachers age 65.
[4] Worker reachers age 67.

Assumptions: Amount deposited grows at 5 percent per year. Rate of interest equals 9 percent.

Appendix.—The NCPA Proposal

The concept behind the Health Bank IRA proposal is to allow workers to withdraw an amount equal to all or almost of the payroll taxes they now pay into Medicare and place those funds into a private savings account. These funds would be use to pay for medical expenses and private health insurance in retirement, in lieu of Medicare. The federal government's role would be limited to providing catastrophic health insurance, through Medicare, and means-tested benefits, through the Medicaid program.

I. CHANGES IN THE LONG-TERM STRUCTURE OF MEDICARE

Catastrophic coverage

Medicare will be restructured so that two types of benefits are provided: basic health insurance and catastrophic health insurance. Catastrophic health insurance will apply to very large medical bills. The size of medical expense deemed to be catastrophic will grow through time in a manner described below.

Basic coverage

In order to insure that money spent on health care for the elderly bears some reasonable relationship to spending on other goods and services which people also desire, the amount spent on basic Medicare health insurance will be about $1,500 per beneficiary in 1982 prices, and will be allowed to grow through time in line with annual increases in the average wage in the economy. In order to keep Medicare spending from rising above this maximum, deductibles and co-payments will be increased when necessary.

II. THE HEALTH BANK IRA

Refundable tax credits

All workers under the age of 65 will be allowed to make annual contributions to designated Health Bank IRA accounts and receive a 100 percent income tax credit for these contributions. The annual contribution will be a fixed sum of money called an "allowable contribution." Any worker who chooses the IRA option must deposit the entire allowable contribution in his IRA account. Workers may place additional funds in their Health Bank IRAs, but they will not receive a tax credit for these additional amounts.

In order to encourage low-income workers to exercise the Health Bank IRA option, tax credits for allowable contributions will be refundable. This means that a worker with no taxable income will be able to make annual contributions to a Health Bank IRA with a tax refund granted by the federal government.

The disposition of health bank IRA funds

Since the Health Bank IRA account is created in order to provide a private alternative to Medicare, funds deposited in this account may be used to purchase only (1) medical care for a worker who has declared retirement at any time after age 59½, (2) medical care for a worker who has reached the age of 65, whether or not retired, or (3) private health insurance to cover medical expenses for cases (1) and (2).

Until Health Bank IRA funds are used to purchase medical care or private health insurance, these funds may be invested, and the return on such investments will be

tax-exempt in accordance with existing IRA rules. Moreover, an individual's Health Bank IRA is part of his estate, and any funds remaining in a Health Bank IRA at the time of an individual's death may be passed on to his heirs.

The quid pro quo

For the first 30 years of contributions under this program, each year that a worker makes an allowable contribution to his Health Bank IRA he will give up the right to 1/30th of the Medicare benefits that he otherwise would have been entitled to. Thus, if a worker contributes only once to an IRA account, when he reaches age 65 he will be entitled to 29/30ths of whatever Medicare pays for basic medical expenses. A worker who makes 15 contributions to an IRA will be entitled at age 65 to one-half of whatever Medicare pays. A worker who makes 30 contributions to an IRA will give up all claims against Medicare for basic medical expenses.

Table A–I illustrates expected annual benefits from Medicare for workers who participate fully in Medicare and for workers who make contributions to their IRAs at every opportunity. The table assumes that the portion of Medicare allocated to basic medical coverage will be about $1,500 per beneficiary in 1982 prices.

TABLE A–I.—EXPECTED ANNUAL BENEFITS FROM MEDICARE DURING THE 30-YEAR PHASE-IN PERIOD

[In 1982 prices]

Worker reaches 65 after:	Full participation	Health Bank IRA participations
5 years	$1,500	$1,250
10 years	1,500	1,000
15 years	1,500	750
20 years	1,500	500
25 years	1,500	250
30 years	1,500	.....

The allowable contribution

The purpose of the Health Bank IRA option is to encourage workers to engage in a savings program which will furnish them with a sum of money from which they can fund their own medical expenses during their retirement years. In order to assure that this purpose is achieved, it is important to structure the program so that workers find it in their financial self-interest to exercise the IRA option. Workers will be financially encouraged to exercise the IRA option in two ways. First, the allowable contribution to a Health Bank IRAs will be an amount which is greater than the discounted present value of the Medicare benefits which the worker will forego as a result of exercising the option. Second, workers who have exercised the IRA option at any time during their working years will have an opportunity to buy back into Medicare.

Table A–II shows what the allowable contributions must be in order to make IRA deposits financially attractive to different individuals at different ages, under the current eligibility age of 65. The table also shows what the allowable contribution must be under the eligibility age of 67, proposed by the Advisory Council on Social Security.

TABLE A–II.—AMOUNT OF ANNUAL TAX CREDIT NEEDED TO MAKE OPTING OUT FINANCIALLY ATTRACTIVE

Age	Male		Female	
	White	Black	White	Black
Eligibility age 65:				
20	$267	$67	$493	$350
30	373	141	647	471
35	455	205	765	565
Eligibility age 67:				
20	191	0	409	271
30	272	53	531	365

TABLE A–II.—AMOUNT OF ANNUAL TAX CREDIT NEEDED TO MAKE OPTING OUT FINANCIALLY ATTRACTIVE—Continued

Age	Male		Female	
	White	Black	White	Black
35	333	98	623	436

Note.—The tax credit grows at the rate of growth of the average wage. It is assumed that the rate of interest paid on IRA accounts is equal to the rate of growth of the average wage. This is a very conservative assumption. Under more realistic assumptions about the rate of interest, the amounts above would be much lower.

As the table shows, each new generation of male workers entering the labor market can be encouraged to opt out of Medicare (with eligibility at 65) for an allowable contribution of $267. With an eligibility age of 67, each new generation of male workers can be encouraged to opt out with an allowable contribution of $191.

Table II–A also shows that if the allowable contribution is set sufficiently high to induce white male workers to opt out of Medicare, this amount will be considerably greater than the minimum amount needed to induce black male workers to opt out of Medicare. Thus, unlike Medicare which discriminates against blacks and other minorities with low life expectancies, the Health Bank IRA option benefits blacks and other minorities relative to whites. In fact, as we have seen, with an eligibility age of 67, black males can expect to gain nothing from Medicare.

A special problem arises as a result of the different life expectancies of men and women. On the average, white females entering the labor market today can expect benefits from Medicare which are almost two times larger than the expected benefits for white males. Black females have expected Medicare benefits which are more than five times larger than those of their male counterparts. Under the IRA option, if all workers are given the same allowable contribution, regardless of sex, then the allowable contribution must be roughly equal to $500 to induce women as well as men to opt out of Medicare with the current eligibility age.

The buy-back option

Every worker who makes contributions to a Health Bank IRA will have the opportunity to re-enter Medicare upon reaching the age of 65. In order to buy back into Medicare and obtain full Medicare coverage, the worker must make a lump sum payment to Medicare. This payment will be at least equal to the amount that his Health Bank IRA would have grown to (with prudent investments) and perhaps an additional penalty as well.

Medicare will provide catastrophic health insurance coverage for all workers who reach the age of 65, including those workers who have opted out completely of Medicare's basic insurance plan. The level which medical expenses must reach before they become classified as catastrophic will rise through time and will be related to the size of the fund being accumulated in a representative Health Bank IRA. For example, if an individual makes $500 annual contributions to an IRA account, and if the allowable contribution grows by five percent per year, and the account earns interest return of nine percent, after 30 years it will have grown to $116,200. Since these funds are expected to cover basic medical expenses, the catastrophic level of expenses at this point would probably be in excess of $100,000.

Under Medicare's catastrophic health insurance program there will be co-payments in order to give individuals an incentive to avoid wasteful expenditures. In addition, there will be a recapture provision for those who use Medicare's catastrophic insurance. The recapture provision will allow the government to charge the estate of the deceased the amount of money which the deceased used for catastrophic care prior to death. A provision will have to be made to allow certain transfers to a spouse before the government's claim is paid.

III. THE EVOLUTION OF MEDICARE AND MEDICAID

Medicare taxes

Since contributions to Health Bank IRAs earn income tax credits, the payroll tax, including that portion of the payroll tax designated for Medicare, will be unaffected. This means that the payroll tax can continue to serve as the major (or even exclusive) source of funds from which to fund Medicare expenditures.

As individuals exercise their IRA options, however, the total amount of Medicare spending will begin to fall through time, relative to what it otherwise would have

been. This means that, in principle, the payroll tax can be progressively lowered through time.

Medicare benefits

This proposal is structured to encourage every member of each new generation of workers to opt out of Medicare. Even low-income workers will be able to build up a fund from which to finance their own health care expenditures during their retirement years.

A small percentage of the population may remain in Medicare because of ignorance of, or indifference to, the IRA option. In addition, because of the "buy back" option, some individuals may choose to buy back into Medicare at the age of 65. Because of the adverse selection problem associated with the "buy back" system, however, Medicare will look very unattractive to young workers. In addition, it is unlikely that those who do buy back into Medicare will gain much by doing so.

As a result, the Health Bank IRA program will ultimately lead to a virtual phasing out of the basic medical insurance part of Medicare. Ultimately, Medicare will become almost exclusively a catastrophic health insurance plan.

Medicaid

Under this proposal, Medicaid will continue in some form to pay for the medical expenses of individuals with few assets and little or no money income. It is anticipated, however, that there will be little need for Medicaid for people 65 and older. Even those who live below the poverty level during their working years should have sufficient Health Bank IRA funds to make Medicaid unnecessary during their retirement years.

IV. SHORT-TERM FINANCIAL EFFECTS ON THE FEDERAL BUDGET

If not other changes are made in government spending or taxation, tax credits given for funds placed in Health Bank IRA accounts will decrease federal revenues, and, therefore, increase the size of the budget deficit. However, for each one-dollar increase in the deficit there is a corresponding one-dollar increase in the supply of credit (through IRA accounts). This means that for every extra dollar the government needs to borrow as a result of this program there will be one extra dollar added to the supply of loanable funds in the credit market through Health Bank IRAs.

As a consequence, the introduction of this program will not cause interest rates to rise, or create any additional inflationary pressure in the economy. Even if larger deficits result, funds will be available to finance these deficits without "crowding out" private investment.

ABOUT THE CONTRIBUTORS

Peter Ferrara is the author of "Social Security: The Inherent Contradiction," a book which was widely acclaimed for its penetrating analysis of the crisis of Social Security and which advocated an IRA alternative to the Social Security system. A graduate of Harvard Law School, Mr. Ferrara recently left his post as a senior staff member at the White House Office of Policy Development and is currently a member of Shaw, Pittman, Potts and Trowbridge, a Washington law firm.

John Goodman is the author of four books, including "Social Security in the United Kingdom: Contracting out of the System," a study of a social security system which allows partial opting out. Dr. Goodman is President of the National Center for Policy Analysis and Director of the Center for Health Policy Studies at the University of Dallas.

Gerald Musgrave is the author of over 30 publications, including work on "The Effect of Social Security on Saving and Capital Formation," health economics and computational econometrics. He is the Associate Editor and Book Review Editor of Business Economics, the journal of the National Association of Business Economists. Dr. Musgrave is leaving his position as Adjunct Professor of Economics at the University of Michigan to become President of Safeware Computer Systems.

Richard Rahn served as a member of the 1982-83 Social Security Advisory Council. Dr. Rahn is Vice-President and Chief Economist of the U.S. Chamber of Commerce and is the former Executive Director of the American Council for Capital Formation.

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STATEMENT OF SAMUEL D. CHILCOTE, JR., PRESIDENT, TOBACCO INSTITUTE

The most significant aspect of the testimony on the Medicare Program presented to the Health Subcommittee by two dozen witnesses on September 13 was the strong and overwhelming consensus that the hospital insurance trust fund must be kept solvent by curbing cost growth of the program rather than by raising taxes of any kind or shifting more of the burden to the beneficiaries. The merit of the Kennedy-Gephardt proposal is that it follows this principle, which ought to guide any reform of the Medicare system.

The Tobacco Institute wishes to associate itself with the positions taken by the majority at the hearing—that the wildly escalating costs of this program must be curtailed. It wishes further to emphasize its opposition to the proposal adopted by a 7-6 vote by the Advisory Council on Social Security (after once having been voted down) that excise taxes on alcohol and tobacco be earmarked for the hospital insurance trust fund.

In the brief statement that follows, I would like to direct the subcommittee's attention to the many objections to this proposal voiced by a wide spectrum. These groups concur that such a proposal offers neither a wise nor fair solution to the urgent problem facing one of our Nation's most important social programs.

The American Association of Retired Persons (AARP), in its testimony before this committee (September 13, 1984), called for a "more rational, less cost escalating health care system." The group emphasized health care cost containment as paramount and opposed the generating of any new resources until such costs could be considered under control. Specifically, the AARP disagreed with the Social Security Advisory Council's recommendations that revenues from increased alcohol and tobacco excise taxes should be earmarked for the hospital insurance (HI) trust fund.

Organized labor opposes this proposal, and supported the dissenting opinions of Stanford Arnold and Alvin Heaps on the subject of earmarking.

Mr. Ray Denison, director of the department of legislation of the AFL-CIO, in his testimony before this committee (Sept. 13, 1984), fully endorsed the Social Security Advisory Committee's minority report. He opposed the increasing of taxes on alcohol and tobacco to raise revenue for the Medicare trust fund, claiming that the "negative economic and social effects of such a decision were not given sufficient consideration by the [Social Security Advisory] Council." Denison described earmarking as "poor tax policy" and pointed out the extreme regressivity of excise taxes on products such as alcohol and tobacco.

Likewise, the Food and Allied Services Trade Department of the AFL-CIO (FAST) and the Bakery, Confectionery and Tobacco Workers International Union (BC&T) were alarmed at the prospect of financing Medicare with revenues provided by such regressive taxes. In testimony submitted to this committee (September 13, 1984), both groups acknowledged the already significant tax burden borne by low and moderate income people and rejected the Social Security Advisory Council's proposal which would fund Medicare at the further expense of these individuals.

Furthermore, FAST and BC&T opposed earmarking of excises on alcohol and tobacco on the grounds that these taxes do not provide stable funding. BC&T mentioned the fact that "the 100 percent increase in the Federal excise tax on cigarettes—from 8¢ to 16¢ in January, 1983—yielded only a 70 percent increase in net revenue in the first quarter of that year." Indeed, as both FAST and BC&T pointed out, alcohol and tobacco are already two of the most highly taxed commodities in the United States: It is only a matter of time until they reach the limit in the amount of revenue they can produce.

It does not seem wise to finance the program that so many millions of elderly and disabled Americans depend on with such unreliable resources.

There is one more piece of testimony I would like to mention in this statement—that of Mr. Paul Craig Roberts, from the Center for Strategic and International Studies at Georgetown University, before the Quadrennial Advisory Council on Social Security (July 19, 1983).

In this statement, Mr. Roberts criticized as unstable financing options which included tax increases and transfers from general revenues. He claimed that a solution to the HI crisis facing Medicare could be found if a part of the surplus in the OASIDI funds which will build up during the next 25 years were channeled into the hospital insurance trust fund.

Both liberal and conservative would seem to agree: It is no way to solve the impending crisis facing Medicare, indeed, the future of health care in this country.

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